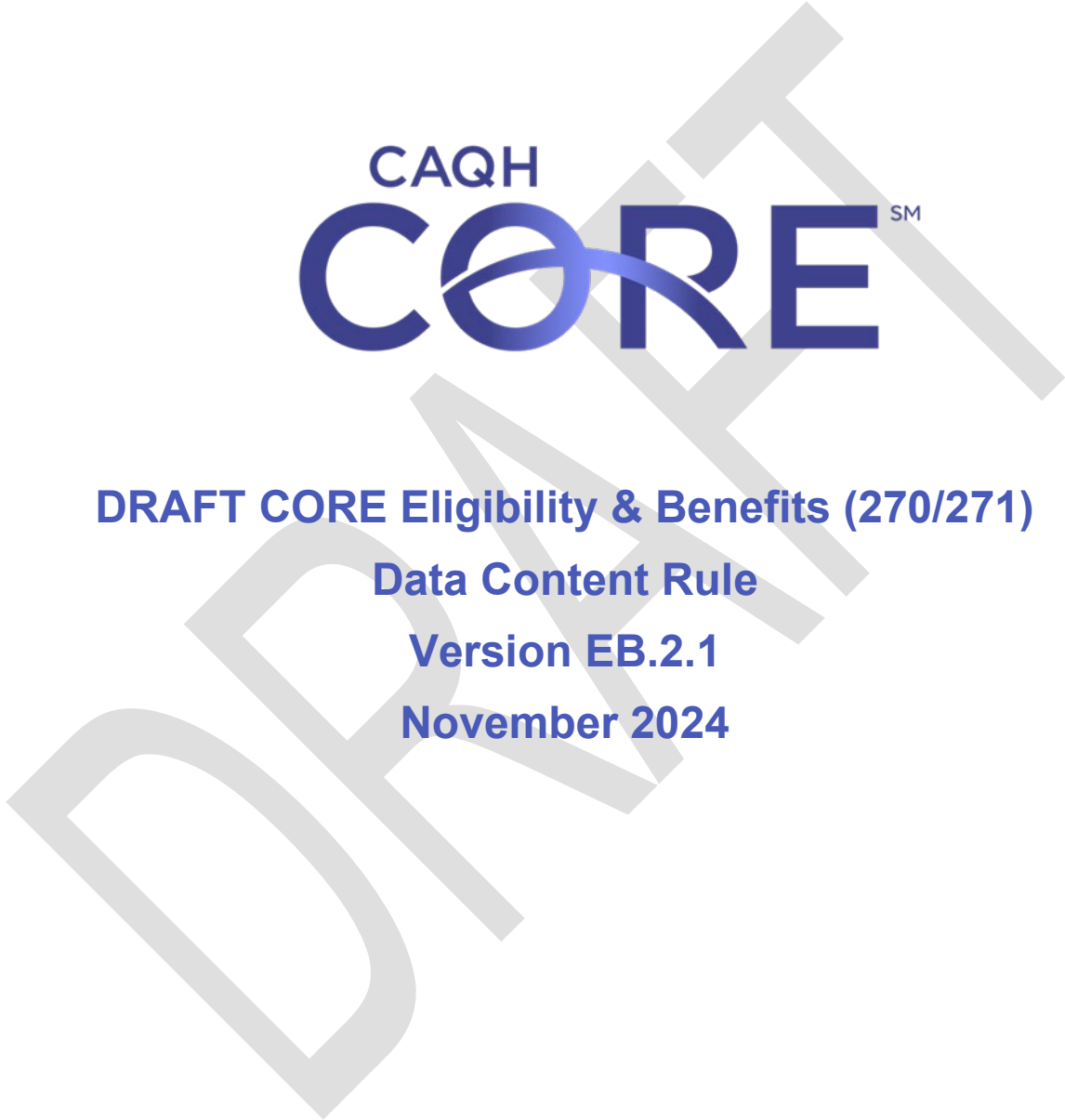


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DRAFT CORE Eligibility & Benefits (270/271)
Data Content Rule
Version EB.2.1
November 2024



**CAQH Committee on Operating Rules for Information Exchange (CORE)
DRAFT Eligibility & Benefits (270/271) Data Content Rule vEB.2.1
Draft for Review Work Group**

12 **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: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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 <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • CORE-required Service Type Codes • CORE-required Categories of Service 	November 2024

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		<ul style="list-style-type: none">• Procedure Code Requests and Responses <p>Additional requirements for:</p> <ul style="list-style-type: none">• Specifying Dental Benefit Limitations• Electronic Policy Access of Required Information <p>Re-organization of Rule Contents:</p> <ul style="list-style-type: none">• Separation of Appendix into a companion document	
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125 **Introduction**

126 Four Phase I & II CORE Eligibility & Benefits (270/271) Data Content Operating Rules were combined in
127 2020 to create the CORE Eligibility & Benefits (270/271) Data Content Rule (see Revision History) as part
128 of the CORE Eligibility & Benefit Rule Set. A single rule to support all data content operating rule
129 requirements is consistent with all other CORE rule sets and simplifies ongoing maintenance. The rule is
130 divided into three main sections:

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

134 In 2021, CORE launched a Task Group to evaluate opportunity areas for operating rule enhancement for
135 the Electronic Delivery of Patient Financial and Benefit Information Rule.

136 In 2024, CORE collaborated with the National Council for Prescription Drug Plans (NCPDP) to outline
137 how the X12 standard should be used to communicate a health plan member's drug coverage under the
138 member's medical benefit. Additionally, partnership with the National Dental EDI Council (NDEDIC) and
139 the American Dental Association (ADA) resulted in proposals that align communication of dental benefits
140 with the expectations industry has for medical coverage. Outputs from work with NCPDP, NDEDIC, and
141 the ADA were reviewed by a Task Group and are included in this rule.

142 For ease of reference, updated or the addition of new rule requirements are highlighted in grey.

143 **1 Electronic Delivery of Patient Financial and Benefit Information**

144 ***1.1. Issue to be Addressed and Business Requirement Justification***

145 To electronically determine a patient's eligibility and benefits, providers need to have a robust ASC X12
146 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270/271). This
147 robust response includes the health plans providing financial information for base and remaining
148 deductible, co-insurance, co-payment and coverage and benefit information pertaining to telemedicine,
149 authorization or certification indication, and tiered benefits for those service types and procedure codes.
150 HIPAA provides a foundation for the electronic exchange of eligibility and benefits information but does
151 not go far enough to ensure that today's paper-based system can be replaced by an electronic,
152 interoperable system. HIPAA's current mandated data scope does not require all financial and benefit
153 information needed by providers, and HIPAA neither addresses the standardization of data definitions nor
154 contains business requirements by which the HIPAA-outlined data can flow. Future standards developed
155 by ASC X12 and adopted by HIPAA may address these issues. In the meantime, businesses are seeking
156 solutions that can be used today.

157 Using the available but not-required (situational) elements of the v5010 270/271, the CORE Eligibility &
158 Benefits (270/271) Data Content Rule defines the specific business information requirements that health
159 plans must return, and vendors, clearinghouses and providers must use if they want to be CORE-
160 certified. As with all CORE rules, these requirements are base requirements, and it is expected many
161 CORE-certified entities will add to these requirements as they work towards the goal of administrative
162 interoperability.

163 This rule requires: the delivery of base, remaining and benefit-specific deductibles; return of co-payment
164 and co-insurance amounts; communication of telemedicine, remaining coverage, and tiered benefits;
165 indication if authorization or certification is required; and provides a list of CORE-required service type
166 codes and CORE-required categories of service for procedure codes. For certain categories of service
167 and procedure codes, requirements specify that information that supports dental plan benefits and
168 medication coverage must also be returned if requested.

169 By requiring the delivery and use of this financial and benefit information via the existing v5010 270/271
170 HIPAA-adopted standard, the CORE Eligibility & Benefits (270/271) Data Content Rule helps provide the
171 information that is necessary to automate electronic eligibility and benefits inquiry processes more fully
172 and thus reduce the cost of today's more manual processes.

173 **1.2. Scope**

174 **1.2.1. What the Rule Applies To**

175 This CORE rule conforms with and builds upon the v5010 TR3 implementation guide and specifies the
176 minimum content that an entity must include in the v5010 271.
177

178 **1.2.2. When the Rule Applies**

179 This rule applies when:

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

181 And

182 One of the following is true:

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

184 Or

- 185 • A health plan and its agent receives an explicit v5010 270 for a specific service type required in
186 §1.3.2.3 of this rule;

187 Or

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

190 **1.2.3. What the Rule Does Not Require**

191 This rule does not require any entity to modify its use and content of:

- 192 • Other loops and data elements that may be submitted in the v5010 270 not addressed in this rule
193 (see §1.2.4)

194 And

- 195 • Other loops and data elements that may be returned in the v5010 271 not addressed in this rule
196 (see §1.2.4).
197

198 **1.2.4. Applicable Loops & Data Elements**

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

- 201 • 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

- 202 • Segment in the v5010 271:

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
HSD01-673 Quantity Quantifier
HSD02-380 Quantity
HSD05-615 Time Period Qualifier
HSD06-616 Number of Periods
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
HSD01-673 Quantity Quantifier
HSD02-380 Quantity
HSD05-615 Time Period Qualifier
HSD06-616 Number of Periods
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

203 **1.2.5. Outside the Scope of this Rule**

204 This rule does not require entities to internally store the data elements listed in §1.2.4 or any other data
 205 elements in conformance with this rule, but rather requires that all entities conform to this rule when
 206 conducting the v5010 270/271 transactions electronically. Entities may store data internally any way they
 207 wish but must ensure the data conform to applicable CORE rules when inserting that data into outbound
 208 transactions.

209 **1.2.6. Assumptions**

210 The following assumptions apply to this rule:

- 211 • This rule is a component of the larger set of CORE Eligibility & Benefits Operating Rules; as such,
 212 all the CORE Guiding Principles apply to this rule and all other rules.
- 213 • Requirements for the use of the applicable loops and data elements apply only to the v5010
 214 270/271.
- 215 • Health plans and their agents are able to accurately maintain benefit and eligibility data received
 216 or created in a reasonable timeframe.
- 217 • This rule is not a comprehensive companion document specifying the complete content of either
 218 the v5010 270 or v5010 271 transactions. The focus in this rule is on specifying requirements for
 219 the v5010 271 to address the CORE eligibility and benefits data content requirements for health
 220 plan benefits and services and related patient financial responsibility.

221 **1.2.7. Abbreviations and Definitions Used in this Rule**

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

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

229 **Explicit Inquiry:** In contrast to a Generic Inquiry, an Explicit Inquiry is a v5010 270 Health Care Eligibility
 230 Benefit Inquiry that contains a Service Type Code other than and not including “30” (Health Benefit Plan
 231 Coverage) in the EQ01 segment of the transaction. An Explicit Inquiry asks about coverage of a specific
 232 type of benefit, for example, “78” (Chemotherapy). (See §1.3.2.3)

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

236 **Health Plan Base Deductible:** The dollar amount of covered services based on the allowed benefit that
237 must be paid by an individual or family per benefit period before the health benefit plan begins to pay its
238 portion of claims. The benefit period may be a specific date range of one year or other as specified in the
239 plan.

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

242 **In/Out of Network¹:** A provider network is a list of the doctors, other health care providers, and hospitals
243 that a plan contracts with to provide medical care to its members. These providers are called “network
244 providers” or “in-network providers.” A provider that isn’t contracted with the plan is called an “out-of-
245 network provider.”

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

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

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

255 **Support [Supported] Procedure Code:** Support [or Supported] means that the health plan (or
256 information source) must have the capability to receive a v5010 270 for a specific Procedure Code and to
257 respond in the corresponding v5010 271 in accordance with this rule. Examples referenced in this rule
258 can include CPT, HCPCS, CDT, ICD-10-PCS, or NDC.

259 **Telemedicine/Telehealth:** When a provider delivers care for a patient without an in-person office visit, for
260 example, online with internet access on a computer, tablet, or smartphone or via telephone.

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

264 **1.3. Service Type Codes: Electronic Delivery of Patient Financial and Benefit Information** 265 **Rule Requirements**

266 **1.3.1. Basic Requirements for Submitters (Providers, Provider Vendors, and Information** 267 **Receivers)**

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

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

273 **1.3.2. Basic Requirements for Health Plans and Information Sources**

274 A health plan and its agent must comply with all requirements specified in this rule when returning the
275 v5010 271 when the individual is located in the health plan’s (or information source’s) system.

276 **1.3.2.1. Health Plan Name**

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

281 **1.3.2.2. Eligibility Dates**

282 The v5010 270 may request a benefit coverage date 12 months in the past or up to the end of the current
283 month. If the inquiry is outside of this date range and the health plan (or information source) does not
284 support eligibility inquiries outside of this date range, the v5010 271 must include the AAA segment with

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

285 code “62” Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code
286 data element.

287 **1.3.2.3. Requirements for a Response to an Explicit Inquiry for a CORE**
288 **Required Service Type**

289 A health plan and its agent must support an explicit v5010 270 for each of the CORE service types
290 specified in the [appendix](#), in *Table 1 – Eligibility & Benefits CORE Service Type Codes*, returning a v5010
291 271 as specified in §1.3.2.4 through §1.3.2.13.

292 **1.3.2.4. Specifying Status of Health Benefits Coverage**

293 For the discretionary Service Type Codes identified in the [appendix](#), in *Table 1 – Eligibility & Benefits*
294 *CORE Service Type Codes*, when the health plan is exercising its discretion to not return patient financial
295 responsibility, the coverage status of the specific benefit (service type) must be returned regardless of
296 whether or not that status is separate and distinct from the status of the health plan coverage.
297 When a service type covered by this rule is a covered benefit for in-network providers only and not a
298 covered benefit for out-of-network providers, a health plan and its agent must indicate the non-covered
299 status for out-of-network providers for each service type using EB12-1073 Yes/No – In Plan Network
300 Indicator as follows:

- 301 • EB01 = I–Non-Covered
- 302 • EB03 = <Applicable Service Type Code>
- 303 • EB12 = N

304 **1.3.2.5. Patient Financial Responsibility and Benefit Information**

305 A health plan and its agent must return the patient financial responsibility for base and remaining
306 deductible, co-insurance and co-payment and benefit information pertaining to telemedicine and
307 authorization/certification indication as specified in §1.3.2.6 through §1.3.2.13 for each of the service type
308 codes returned. The health plan (or information source) may, at its discretion, elect not to return patient
309 financial responsibility and benefit information (deductible, co-payment, co-insurance, telemedicine,
310 authorization/certification) for service type codes indicated as discretionary as specified in the [appendix](#),
311 in *Table 1 – Eligibility & Benefits CORE Service Type Codes*.

312 This discretionary reporting of patient financial responsibility and benefit information does not preempt the
313 health plan’s (or information source’s) requirement to report patient financial responsibility and benefit
314 information for deductible, co-payment, co- insurance, telemedicine, and authorizations/certification for all
315 other Service Type Codes as specified in the [appendix](#), in *Table 1 – Eligibility & Benefits CORE Service*
316 *Type Codes*.

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

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

- 321 • A code is too general for a response to be meaningful (e.g., 1 – Medical);
- 322 • A code is typically a “carve-out” benefit (e.g., AL – Vision) where the specific benefit information is
323 not available to the health plan or information source; Or
- 324 • A code is related to behavioral health or substance abuse (e.g., AI - Substance Abuse) where
325 privacy issues may impact a health plan or information source’s ability to return information.

326 See the [appendix](#), *Table 1 – Eligibility & Benefits CORE Service Type Codes*, for a visual view of Service
327 Type Codes and reporting requirements.

328 All date and date range reporting requirements for Patient Financial Responsibility are specified in
329 §1.3.2.9.

330 **1.3.2.6. Specifying Deductible Amounts**

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

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

335 **1.3.2.6.1. Specifying the Health Plan Base Deductible**

336 A health plan and its agent must return the Health Plan base deductible as defined in §1.2.7 of this rule
337 that is the patient financial responsibility, including both individual and family deductibles (when
338 applicable) in Loops 2110C/2110D only when the status of the health plan coverage as required in
339 §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and EB03=30 – Health Benefit Plan
340 Coverage as follows:

- 341 • EB01 = C–Deductible
- 342 • EB02 = FAM–Family or IND–Individual as appropriate
- 343 • EB03 = 30 – Health Benefit Plan Coverage
- 344 • EB06 = <Applicable Time Period Qualifier code; see the [appendix, Table 2 – CORE](#)
345 [Recommended Time Period Qualifier Codes](#) for recommended qualifiers.>
- 346 • EB07 = Monetary amount of Health Plan base deductible

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

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

- 352 • EB12 = N or Y as applicable

353 **1.3.2.6.2. Specifying the Health Plan Remaining Deductible**

354 A health plan and its agent must return the Health Plan remaining deductible, that is the patient financial
355 responsibility, including both individual and family remaining deductibles (when applicable) in Loops
356 2110C/2110D only when the status of the health plan coverage as required in §1.3.2.4 is equal to one of
357 the active coverage codes 1 through 5 and EB03=30 – Health Benefit Plan Coverage as follows:

- 358 • EB01 = C–Deductible
- 359 • EB02 = FAM–Family or IND–Individual as appropriate
- 360 • EB03 = 30 – Health Benefit Plan Coverage
- 361 • EB06 = 29–Remaining
- 362 • EB07 = Monetary amount of Health Plan remaining deductible

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

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

- 368 • EB12 = N or Y as applicable

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

372 **1.3.2.6.3. Specifying the Benefit-specific Base Deductible**

373 A health plan and its agent must return the Benefit-specific base deductible as defined in §1.2.7 of this
374 rule that is the patient financial responsibility, including both individual and family deductibles (when
375 applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the
376 specific benefit as required in §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and
377 EB03=30–Health Benefit Plan Coverage as follows:

- 378 • EB01 = C–Deductible
- 379 • EB02 = FAM–Family or IND–Individual as appropriate
- 380 • EB03 = <the Service Type Code indicating the specific benefit to which the deductible applies>
- 381 • EB06 = <Applicable Time Period Qualifier code; see the [appendix, Table 2 – CORE](#)
382 [Recommended Time Period Qualifier Codes](#) for recommended qualifiers.>

- 383
- EB07 = Monetary amount of Benefit-specific base deductible

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

- 386
- EB12 = N or Y as applicable

387 **1.3.2.6.4. Specifying the Benefit-specific Remaining Deductible**

388 A health plan and its agent must return the Benefit-specific remaining deductible, that is patient financial
389 responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D
390 only when the status of the health plan coverage and the status of the specific benefit as required in
391 §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and EB03#30–Health Benefit Plan
392 Coverage as follows:

- 393
- EB01 = C–Deductible
 - 394 • EB02 = FAM–Family or IND–Individual as appropriate
 - 395 • EB03 = <the Service Type Code indicating the specific benefit to which the deductible applies>
 - 396 • EB06 = 29 – Remaining
 - 397 • EB07 = Monetary amount of Benefit-specific remaining deductible

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

- 400
- EB12 = N or Y as applicable

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

404 Returning the Benefit-specific remaining deductible is required except for those service types specified as
405 exceptions for discretionary reporting in §1.3.2.5.

406 **1.3.2.7. Specifying Co-Payment Amounts**

407 A health plan and its agent must return the patient financial responsibility for co-payment for each of the
408 Service Type Codes returned as specified as follows:

- 409
- EB01 = B–Co-Payment
 - 410 • EB02 = FAM–Family or IND–Individual as appropriate
 - 411 • EB07 = Monetary amount of Benefit-specific Co-payment

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

- 414
- EB12 = N or Y as applicable

415 See §1.3.2.5 for discretionary reporting exceptions.

416 **1.3.2.8. Specifying Co-Insurance Amounts**

417 A health plan and its agent must return the patient financial responsibility for co-insurance for each of the
418 Service Type Codes returned as follows:

- 419
- EB01 = A–Co-Insurance
 - 420 • EB02 = FAM–Family or IND–Individual as appropriate
 - 421 • EB08 = Percent for each Benefit-specific Co-insurance

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

- 424
- EB12 = N or Y as applicable

425 See §1.3.2.5 for discretionary reporting exceptions.

426 **1.3.2.9. Specifying the Health Plan Base Deductible Date**

427 When the Health Plan Base Deductible date is not the same date as the Health Plan Coverage Date for
428 the Individual a health plan and its agent must return date specifying the begin date for the base Health
429 Plan deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and
430 EB03=30–Health Plan Benefit Coverage and EB01=C–Deductible as follows:

- 431 • DTP01 = 346 Plan Begin
- 432 • DTP02 = D8–Date Expressed in Format CCYYMMDD
- 433 • DTP03 = the date applicable to the time period as specified in EB06

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

436 Alternatively, a health plan and its agent may return a range of dates specifying the begin and end dates
437 for the base Health Plan Base deductible only in Loops 2110C/2110D where EB01 = active coverage
438 code 1 through 5 and EB03=30–Health Plan Benefit Coverage and EB01 = C–Deductible as follows:

- 439 • DTP01 = 291–Plan
- 440 • DTP02 = RD8–Date Expressed in Format CCYYMMDD-CCYYMMDD
- 441 • DTP03 = the range of dates applicable to the time period as specified in EB06

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

444 **1.3.2.10. Specifying Benefit-specific Base Deductible Dates**

445 When the Benefit-specific Base Deductible date is not the same date as the Health Plan Coverage Dates
446 for the Individual, a health plan and its agent must return a date specifying the begin date for the base
447 Benefit-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5
448 and EB03≠30–Health Plan Benefit Coverage and EB01=C–Deductible as follows:

- 449 • DTP01 = 348–Benefit Begin
- 450 • DTP02 = D8–Date Expressed in Format CCYYMMDD
- 451 • DTP03 = the date applicable to the time period as specified in EB06

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

454 Alternatively, a health plan and its agent may return a range of dates specifying the begin and end dates
455 for the base Benefit-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1
456 through 5 and EB03≠30–Health Plan Benefit Coverage and EB01=C–Deductible as follows:

- 457 • DTP01 = 292–Benefit
- 458 • DTP02 = RD8–Date Expressed in Format CCYYMMDD-CCYYMMDD
- 459 • DTP03 = the range of dates applicable to the time period as specified in EB06

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

462 **1.3.2.11. Specifying Telemedicine Benefits**

463 When a service type code is covered for telemedicine², a health plan and its agent must use the Centers
464 for Medicare and Medicaid Services External Place of Service Codes for Professional Claims Code 02
465 (Telehealth Provided Other than in Patient’s Home) or 10 (Telehealth Provided in Patient’s Home) , in
466 Segment III³ (SUBSCRIBER/DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION),
467 within Data Element III02 (INDUSTRY CODE) to indicate what service or benefit is available for
468 telemedicine as follows.

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 Reference ASC X12N v5010X279 271/2115C/2115D III Segment

- 469
470 EB Segment:
- 471 ▪ EB01 = Eligibility or Benefit Information Code used to Identify the Eligibility or Benefit Information
 - 472 ▪ EB02 = FAM–Family or IND–Individual as appropriate
 - 473 ▪ EB03 = <Service Type Code that is available for Telemedicine>

- 474 III Segment:
- 475 ▪ III01 = ZZ Place of Service Codes for CMS Professional Services
 - 476 ▪ III02 = 02 Telehealth Provided Other than in Patient's Home or 10 Telehealth Provided in Patient's
 - 477 Home (as appropriate)

478
479 When telemedicine benefits differ for in- and out-of-network, two occurrences of the EB segment must be
480 returned using EB12 with codes N and Y as follows:

- 481 • EB12 = N or Y as applicable

482 **1.3.2.12. Specifying Maximum and Remaining Coverage Benefits**

483 A health plan and its agent must return maximum benefit limitations and return remaining benefits for
484 each maximum benefit limitation for the CORE-required remaining coverage benefit service types
485 specified in the [appendix](#), in *Table 1 – Eligibility & Benefits CORE Service Type Codes* using two EB
486 segment occurrences.

487 **1.3.2.12.1. Specifying Maximum Benefit**

488 A health plan and its agent must return maximum benefit limitations in an EB segment as follows:

- 489 ▪ EB Segment
 - 490 • EB01 = F Limitations
 - 491 • EB03 = <Applicable CORE-required STC for Remaining Benefits>
 - 492 • EB06 = <Applicable Time Period Qualifier code; the [appendix](#), *Table 2 – CORE*
 - 493 *Recommended Time Period Qualifier Codes* for recommended qualifiers>
 - 494 • EB07 = Monetary Amount as qualified by EB01 (when applicable)
 - 495 • EB08 = Percentage Rate as qualified by EB01 (when applicable)
 - 496 • EB09 = M2 Maximum - Use to specify the units conveyed in EB10 (when applicable)
 - 497 • EB10 = Benefit Quantity (when applicable)

498 **1.3.2.12.2. Specifying Remaining Benefit**

499 A health plan and its agent must return the related remaining benefit limitation in an EB segment as
500 follows:

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

509 **1.3.2.12.3. Remaining Benefit with Date**

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

- 512 • EB Segment
 - 513 • EB03 = < Applicable CORE-required STC for Remaining Benefits >

- 514 • EB06 = <Applicable Time Period Qualifier code; see the [appendix, Table 2 – CORE](#)
- 515 [Recommended Time Period Qualifier Codes](#) for recommended qualifiers>
- 516
- 517 • DTP Segment
- 518 • DTP01 = 348 Benefit Begin
- 519 • DTP02 = D8 Date Expressed in Format CCYYMMDD
- 520 • DTP03 = Next Eligible Date as applicable to the time period specified in EB06

521 **1.3.2.13. Specifying Authorization/Certification**

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

- 526 • EB11 = N or Y as applicable

527

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

- 531 • EB11 = U

532

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

- 535 • EB12 = N or Y as applicable

536 **1.4. Procedure Codes: Electronic Delivery of Patient Financial and Benefit Information**

537 **Rule Requirements**

538 **1.4.1. Basic Requirements for Submitters (Providers, Provider Vendors and Information**

539 **Receivers)**

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

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

545 **1.4.2. Basic Requirements for Health Plans and Information Sources**

546 A health plan and its agent must comply with all requirements specified in this rule when returning the
 547 v5010 271 when the individual is located in the health plan's (or information source's) system.

548 **1.4.2.1. Health Plan Name**

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

553 **1.4.2.2. Eligibility Dates**

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

559 **1.4.2.3. Requirements for a Response to an Explicit Inquiry for a CORE**

560 **Required Procedure Code**

561 A health plan and its agent must support an explicit v5010 270 for each procedure code (CPT, HCPCS,
 562 CDT, ICD-10-PCS, or NDC) received that can be placed by the health plan into one or more of the
 563 categories of service as specified in Table 1.4.2.3 returning a v5010 271 as specified in §1.4.2.4 through
 564 §1.4.2.11.

565 **Table 1.4.2.3**
 566

CORE-required Categories of Service for Procedure Codes (CPT, HCPCS, CDT, ICD-10-PCS, or NDC)		
Medical	Dental	Medication
Physical Therapy	Oral and Maxillofacial Surgery	Chemotherapy
Occupational Therapy	Implant Services	Injectables
Imaging	Diagnostic	Infusions
Surgery	Endodontics	Oncology
Internal Medicine	Fixed Prosthodontics	Pain Management
Primary Care	Orthodontics	Biologics
Maternal Health	Periodontics	Compound Drugs
Renal Care	Radiology	Inhalations
	Preventative	Nephrology
	Prosthodontics	Immunosuppressives
	Restorative	Antibiotics
	Specialty Procedures	Hormone Therapy
		Antiemetics

567
 568 When the procedure code(s) received in the v5010 270 cannot be placed by the health plan and its agent
 569 into any of the above types of service categories, as specified in Table 1.4.2.3, the health plan and its
 570 agent should attempt to evaluate and respond appropriately to the request. Note: The health plan and its
 571 agent are strongly encouraged to evaluate and respond to all received procedure code(s).

572 **1.4.2.4. Specifying Status of Health Benefits Coverage**

573 When a procedure code covered by this rule is a covered benefit for in-network providers only and not a
 574 covered benefit for out-of-network providers, a health plan and its agent must indicate the non-covered
 575 status for out-of-network providers for each procedure code using EB12-1073 Yes/No – In Plan Network
 576 Indicator as follows:

- 577 • EB01 = I-Non-Covered
- 578 • EB12 = N
- 579 • EB13 = <Applicable Procedure Code>

580 **1.4.2.5. Patient Financial Responsibility**

581 A health plan and its agent must return the patient financial responsibility for base and remaining
 582 deductible, co-insurance and co-payment as specified in §1.4.2.6 through §1.4.2.8. for each procedure
 583 code returned.
 584 All date and date range reporting requirements for Patient Financial Responsibility are specified in
 585 §1.4.2.9.

586 **1.4.2.6. Specifying Deductible Amounts**

587 A health plan and its agent must return the dollar amount of the base and remaining deductible for
 588 all procedure codes required by §1.4.2.3.
 589 The deductible amount returned must be in U.S. dollars only.

590 **1.4.2.6.1. Specifying the Benefit-specific Base Deductible**

591 A health plan and its agent must return the Benefit-specific base deductible as defined in §1.2.7 of this
592 rule that is the patient financial responsibility, including both individual and family deductibles (when
593 applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the
594 specific benefit as required in §1.4.2.4 is equal to one of the active coverage codes 1 through 5 and
595 EB03#30–Health Benefit Plan Coverage as follows:

- 596 • EB01 = C–Deductible
- 597 • EB02 = FAM–Family or IND–Individual as appropriate
- 598 • EB06 = < Applicable Time Period Qualifier code; see the [appendix, Table 2 – CORE](#)
599 *Recommended Time Period Qualifier Codes* for recommended qualifiers>
- 600 • EB07 = Monetary amount of Benefit-specific base deductible
- 601 • EB13 = < the Procedure Code indicating the specific benefit to which the deductible applies>

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

- 604 • EB12 = N or Y as applicable

605 **1.4.2.6.2. Specifying the Benefit-specific Remaining Deductible**

606 A health plan and its agent must return the Benefit-specific remaining deductible, that is patient financial
607 responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D
608 only when the status of the health plan coverage and the status of the specific benefit as required in
609 §1.3.2.4 is equal to one of the active coverage codes 1 through 5 and EB03#30–Health Benefit Plan
610 Coverage as follows:

- 611 • EB01 = C–Deductible
- 612 • EB02 = FAM–Family or IND–Individual as appropriate
- 613 • EB06 = 29 – Remaining
- 614 • EB07 = Monetary amount of Benefit-specific remaining deductible
- 615 • EB13 = <the Procedure Code indicating the specific benefit to which the deductible applies>

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

- 618 • EB12 = N or Y as applicable

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

622 **1.4.2.7. Specifying Co-Payment Amounts**

623 A health plan and its agent must return the patient financial responsibility for co-payment for each
624 Procedure Code returned as specified as follows:

- 625 • EB01 = B–Co-Payment
- 626 • EB02 = FAM–Family or IND–Individual as appropriate
- 627 • EB07 = Monetary amount of Benefit-specific Co-payment

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

- 630 • EB12 = N or Y as applicable

631 **1.4.2.8. Specifying Co-Insurance Amounts**

632 A health plan and its agent must return the patient financial responsibility for co-insurance for each
633 Procedure Code returned as follows:

- 634 • EB01 = A–Co-Insurance
- 635 • EB02 = FAM–Family or IND–Individual as appropriate

- 636 • EB08 = Percent for each Benefit-specific Co-insurance

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

- 639 • EB12 = N or Y as applicable

640 **1.4.2.9. Specifying Procedure Code-specific Base Deductible Dates**

641 When the Procedure Code-specific Base Deductible date is not the same date as the Health Plan
642 Coverage Dates for the Individual, a health plan and its agent must return a date specifying the begin
643 date for the base Procedure Code-specific deductible only in Loops 2110C/2110D where EB01= active
644 coverage code 1 through 5 and EB03#30–Health Plan Benefit Coverage and EB01=C–Deductible as
645 follows:

- 646 • DTP01 = 348–Benefit Begin
- 647 • DTP02 = D8–Date Expressed in Format CCYYMMDD
- 648 • DTP03 = the date applicable to the time period as specified in EB06

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

651 Alternatively, a health plan and its agent may return a range of dates specifying the begin and end dates
652 for the base Benefit-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1
653 through 5 and EB03#30–Health Plan Benefit Coverage and EB01=C–Deductible as follows:

- 654 • DTP01 = 292–Benefit
- 655 • DTP02 = RD8–Date Expressed in Format CCYYMMDD-CCYYMMDD
- 656 • DTP03 = the range of dates applicable to the time period as specified in EB06

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

659 **1.4.2.10. Specifying Authorization/Certification**

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

- 664 • EB11 = N or Y as applicable

665
666 If authorization or certification requirements cannot be determined for the inquired procedure code and by
667 using data sent in the v5010 270, a health plan and its agent must use EB11 with code U if authorization
668 or certification requirements are not accessible as follows:

- 669 • EB11 = U

670
671 When authorization or certification requirements differ for in- and out-of-network, two occurrences of the
672 EB segment must be returned using EB12 with codes N and Y as follows:

- 673 • EB12 = N or Y as applicable.

674 **1.4.2.11. Specifying Dental Benefit Limitations**

675 When the X12 v5010 270 includes a CORE-required procedure code for a dental category of service, the
676 information source (the health plan or contracted vendor) must return the dental benefit limitations as
677 specified in §1.4.2.11.1 through §1.4.2.11.4.

678 **1.4.2.11.1. Specifying Frequency Limitations**

679 A health plan and its agent must return frequency limitations for procedure codes that align with CORE-
680 required dental categories of service, when applicable, using the EB and HSD Segment as follows:

- 681 • EB Segment:
- 682 ○ EB01 = F-Limitations
- 683 ○ EB13 = <the Procedure Code the frequency limitation applies to>
- 684 • HSD Segment⁴:
- 685 ○ HSD01 = <Applicable Quantity Qualifier>
- 686 ○ HSD02 = Quantity
- 687 ○ HSD05 = <Applicable Time Period Qualifier, see the [appendix, Table 2 – CORE](#)
- 688 *Recommended Time Period Qualifier Codes* for recommended qualifiers>
- 689 ○ HSD06 = Number of Periods

690 **1.4.2.11.2. Specifying Waiting Periods**

691 A health plan and its agent must return waiting periods for procedure codes that align with CORE-
692 required dental categories of service, when applicable, using the EB Segment as follows:

- 693 • EB Segment:
- 694 ○ EB01 = F Limitation
- 695 ○ EB09 = <Applicable Quantity Qualifier for Waiting Period; see [appendix, Table 3 – CORE](#)
- 696 *Recommended Quantity Qualifier Codes* for recommended qualifiers>
- 697 ○ EB10 = Quantity (numeric value of waiting period)
- 698 ○ EB13 = <the Procedure Code where the waiting period applies>

699 **1.4.2.11.3. Specifying Age Limitations**

700 A health plan and its agent must return age limitations for procedure codes that align with CORE-required
701 dental categories of service, when applicable, using the EB Segment as follows:

- 702 • EB Segment:
- 703 ○ EB01 = F Limitation
- 704 ○ EB09 = <Applicable Quantity Qualifier for Age Limitations: S7 – Age, High Value or S8 –
- 705 Age, Low Value; see [appendix, Table 3 – CORE Recommended Quantity Qualifier](#)
- 706 *Codes* for recommended qualifiers>
- 707 ○ EB10 = Quantity (numeric value of age limit)
- 708 ○ EB13 = <the Procedure Code where the age limit applies>

709 **1.4.2.11.4. Specifying Maximum and Remaining Coverage Benefits**

710 A health plan and its agent must return maximum benefit limitations and return remaining benefits for
711 each maximum benefit limitation for procedure codes that align with CORE-required dental categories of
712 service, when applicable, using two EB segment occurrences.

713 **1.4.2.11.4.1. Specifying Maximum Benefit**

714 A health plan and its agent must return maximum benefit limitations in an EB segment as follows:

- 715 ▪ EB Segment
- 716 • EB01 = F Limitations
- 717 • EB06 = <Applicable Time Period Qualifier code; the [appendix, Table 2 – CORE](#)
- 718 *Recommended Time Period Qualifier Codes* for recommended qualifiers>
- 719 • EB07 = Monetary Amount as qualified by EB01 (when applicable)
- 720 • EB08 = Percentage Rate as qualified by EB01 (when applicable)
- 721 • EB09 = M2 Maximum - Use to specify the units conveyed in EB10 (when applicable)
- 722 • EB10 = Benefit Quantity (when applicable)

⁴ When applicable, include HSD03= Unit or Basis for Measurement and HSD04= Sample Selection Modulus

- EB13 = <the Procedure Code where maximum benefit applies>

1.4.2.11.4.2. Specifying Remaining Benefit

A health plan and its agent must return the related remaining benefit limitation in an EB segment as follows:

- EB Segment
 - EB01 = F Limitations
 - 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)
 - EB13 = <the Procedure Code where remaining benefit applies>

1.4.2.11.4.3. Remaining Benefit with Date

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

- EB Segment
 - EB06 = <Applicable Time Period Qualifier code; see the [appendix, Table 2 – CORE Recommended Time Period Qualifier Codes](#) for recommended qualifiers>
 - EB13 = < the Procedure Code where remaining benefit applies >
- 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

1.5. 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 an 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

766 them and the MSG segment content must begin with "MSG*Benefit Tier cannot be determined...".

767 **1.5.2. Provider Tiered Benefit Reimbursement**

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

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

772 AND

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

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

779 **1.6. Electronic Policy Access of Required Information**

780 Health plans and their agents must make data requirements for this transaction easily accessible to
781 submitters of an eligibility and benefits inquiry, either on the plan website or in the transaction-specific
782 companion guide.

783 **2 Normalizing Patient Last Name**

784 **2.1. Issue to be Addressed and Business Requirement Justification**

785 Healthcare providers and health plans have a requirement to uniquely identify patients (aka
786 subscribers, members, beneficiaries) for the purpose of ascertaining the eligibility of the patient for
787 health plan benefits. At a high level, this identification requirement consists of accurately matching:
788 Individuals with records and information that relate to them and to no one else; and
789 Disparate records and information held in various organizations' computer systems about the same
790 individuals.

791 For health plans, this identification requirement currently is met by uniquely numbering the
792 individuals whereby each person (or a subscriber and dependents) is assigned an identifier by the
793 health plan covering the individual, i.e., a subscriber, member or beneficiary ID. This ID is
794 combined with other demographic data about the individual (e.g., first name, last name, date of
795 birth, gender, etc.) and then used in healthcare transactions, such as eligibility inquiries, claims
796 submissions, etc. Healthcare providers obtain this unique identifier from patients, combine it with
797 other demographic data, and then subsequently use it when conducting electronic transactions with
798 health plans, such as insurance verification and claims submissions. The health plans then use this
799 combination of ID and demographic data to attempt to uniquely locate the individual within their
800 systems.

801 However, oftentimes, while the ID may be valid and correct, the other demographic data submitted by the
802 healthcare provider does not match similar demographic data held by the health plans' systems, and such
803 transactions are then rejected or denied.

804 **2.2. Scope**

805 **2.2.1. What the Rule Applies To**

806 This CORE rule for normalizing patient last name applies to the HIPAA-adopted v5010 270/271
807 transactions and specifies the requirements for a CORE-certified health plan (or information
808 source) to normalize a person's last name during any name validation or matching process by the
809 health plan (or information source).

810 This rule applies only to certain characters in a person's last name including:

- 811 • Punctuation values as specified in §2.3.2.3
- 812 • Upper case letters
- 813 • Special characters as specified in §2.3.2.3
- 814 • Name suffixes and prefixes specified as character strings in §2.3.2.2

815 **2.2.2. When the Rule Applies**

816 This CORE rule for normalizing patient last name applies only when:

- 817 • The trading partners are using the ASC X12 Basic Character Set (see §2.2.7 below for
818 explanation).
- 819 And
- 820 • A member ID (MID) is submitted in Loop 2100C of the v5010 270 inquiry transaction.
- 821 And
- 822 • A Last Name (LN) is submitted in Loops 2100C/2100D of the v5010 270 inquiry transaction.
- 823 And
- 824 • The Last Name (LN) is used in the health plan's (or information source's) search and match logic.

825 **2.2.3. When the Rule Does Not Apply**

826 This CORE rule for normalizing patient last name does not apply when:

- 827 • Trading partners have agreed to use the ASC X12 Extended
828 Character Set.
- 829 Or
- 830 • The Last Name (LN) is not used in the health plan's (or information source's) search and
831 match logic.

832 **2.2.4. Recommendation for Validation of Last Name in Other Transactions**

833 Health plans are encouraged to employ a no-more-restrictive name validation logic in other HIPAA
834 administrative transactions than what is employed for the v5010 270/271 transactions.

835 **2.2.5. Applicable Data Elements & Loops**

836 This rule for normalizing patient last name covers the following specified data element
837 and loops in the v5010 270 and v5010 271 transactions:

Loop ID and Name
Loop 2100C Subscriber Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
AAA03-901 Reject Reason Code
INS03-875 Maintenance Type Code
INS04-1203 Maintenance Reason Code
Loop ID and Name
Loop 2100D Dependent Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
AAA03-901 Reject Reason Code
INS03-875 Maintenance Type Code
INS04-1203 Maintenance Reason Code

838

839 **2.2.6. Outside the Scope of this Rule**

840 This rule for normalizing patient last name does not:

- 841 • Require CORE-certified entities to internally store these and other data elements in
842 conformance with this rule, but rather requires that all parties conform to this rule when
843 conducting the HIPAA- adopted v5010 270/271 transactions electronically.
- 844 • Require conversion of letter case and/or special characters by any party for
845 subsequent processing of the data through internal systems.
- 846 • Specify whether or not a health plan (or information source) must validate the full
847 last name or may validate only a portion of the last name.
- 848 • Specify the search criteria used by a health plan (or information source) to identify a patient.

849 **2.2.7. Approved Basic Character Set**

850 The X12 Basic Character Set consists of:

- 851 • Upper case letters from A to Z
- 852 • Digits from 0 to 9
- 853 • Special characters:

854 ! “ & ’ () * + , - . / : ; ? =

- 855 • The space character

856

857 Note: Special characters are removed from this category when used as delimiters.

858 **2.2.8. Use of Extended Character Set**

859 The ASC X12 Extended Character Set as specified in X12.6 Application Control Architecture §3.3.2 is
860 outside the scope of this rule and may be used only by agreement between trading partners. The ASC
861 X12 Extended Character set includes the lowercase letters, other special characters, national characters
862 and select language characters.

863 **2.2.9. Assumptions**

864 The following assumptions apply to this rule:

- 865 • This rule is a component of the larger set of CORE Eligibility & Benefits Operating Rules; as such,
866 all the CORE Guiding Principles apply to this rule and all other rules;
- 867 • Requirements for the use of the applicable loops and data elements apply only to the HIPAA-
868 adopted v5010 270/271;
- 869 • Health plans (and information sources) are able, in a reasonable timeframe, to maintain the
870 relevancy, accuracy, and timeliness of data returned in the v5010 271;
- 871 • This rule is not a comprehensive companion document specifying the complete content of either
872 the v5010 270 or v5010 271 transactions. The focus in this rule is on specifying requirements for
873 the v5010 271 to address the Last Name Normalization requirements;
- 874 • The submitter of the v5010 270 knows which data elements and values were submitted in the
875 v5010 270 (i.e., member identifier, first name, last name, date of birth).

876 **2.3. Normalizing Patient Last Name Rule Requirements**

877 **2.3.1. Basic Recommendations for Submitters of the v5010 270**

878 **2.3.1.1. When Name Suffix is Stored Separately**

879 When the submitter’s system enables the capture and storage of a person’s name suffix in a separate
880 data field, the person’s name suffix should be submitted in the NM107-1039 Name Suffix data element in
881 Loops 2100C/2100D.

882 **2.3.1.2. When Name Suffix is Not Stored Separately**

883 When the person’s name suffix is stored internally as part of a person’s last name, the submitter’s system
884 must attempt to identify and parse the last name data element to extract the name suffix such that it will
885 be transmitted in the NM107-1039 Name Suffix data element in Loops 2100C/2100D.

886 When a name suffix or prefix cannot be stored separately, it should be separated from the last name by a
887 space, a comma or a forward slash (see §2.3.2.3) when storing it.

888 **2.3.2. Basic Requirements for Health Plans & Information Sources**

889 **2.3.2.1. Normalizing Last Name**

890 A health plan (or information source) must:

- 891 • Normalize the last name as submitted in the v5010 270 inquiry
- 892 And
- 893 • Normalize the last name as stored in the health plan's (or information source's) eligibility system
- 894 prior to using the submitted last name and the stored last name.

895 To normalize the submitted and stored last name:

- 896 • Remove all of the character strings specified in §2.3.2.2 when they are preceded by one of the
- 897 punctuation values specified in §2.3.2.3 and followed by a space or when they are preceded by
- 898 one of the punctuation values specified in §2.3.2.3 and are at the end of the data element
- 899 And
- 900 • Remove the special characters specified in §2.2.7 in the name element.

901 If the normalized last name is successfully matched or validated, the health plan (or information source)

902 must return the complete v5010 271 as required in §1 of this rule.
903 If the normalized last name is not successfully matched or validated, the health plan (or information
904 source) must return a v5010 271 response with a AAA segment using the appropriate error code as
905 specified in §3 of this rule regarding errors in Subscriber/Patient Identifiers and Names.

906 **2.3.2.2. Character Strings to be Removed During Name Normalization**

907 The following character strings represent the complete set of character strings to be removed when
908 normalizing a last name as specified in §2.3.3. Any other character strings not included in this section are
909 not covered by this rule. This requirement is in addition to other requirements specified §3 of this rule
910 regarding errors in Subscriber/Patient Identifiers & Names.

- 911 • JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ

912 **2.3.2.3. Punctuation Values Used as Delimiters in Last Name**

913 The following punctuation values represent the recommended set of punctuation values to be used to
914 delimit (separate) a last name from a name suffix or prefix when a name suffix, prefix or a title cannot be
915 stored separately in internal systems.

- 916 • space, comma, forward slash

917 **2.3.3. Required Response for Name Validation**

918 If the name validation is successful, the health plan must return the complete v5010 271 as required by
919 §1 of this rule.

920 If the un-normalized stored last name does not match the un-normalized submitted last name, the v5010
921 271 must include:

- 922 • The last name as stored prior to normalization in the health plan's (or information source's)
- 923 eligibility system in the NM103-1035 Last Name data element in either Loop 2100C or Loop
- 924 2100D as appropriate
- 925 And
- 926 • The INS segment with the appropriate codes as specified in Table 2.3.3 Last Name Validation
- 927 271 INS Segment Reporting Requirements below.

928

929

Table 2.3.3 Last Name Validation v5010 271 INS Segment Reporting Requirements

Validation Results	Patient is Subscriber	Patient is Dependent	INS Segment Returned	Code	NM1 Segment Returned
Valid Last Name	Yes	No	2100C	INS03 = 001 Change INS04 = 25 Change in Identifying Data elements	NM103 = Last Name of Subscriber As Stored in Health Plan's Eligibility System
Valid Last Name	No	Yes	2100D	INS03 = 001 Change INS04 = 25 Change in Identifying Data elements	NM103 = Last Name of Patient As Stored in Health Plan's Eligibility System

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If the name validation fails, the appropriate AAA error code and other data elements as required by §3.3.5 of the AAA Error Codes Reporting Rule regarding errors in Subscriber/Patient Identifiers & Names rule must be returned.

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2.3.4. Basic Requirements for Receivers of the v5010 271

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The receiver of a v5010 271 (defined in the context of this CORE rule as the system originating the v5010 270) is required to comply with §3.3.2 of the AAA Error Codes Reporting Rule regarding Subscriber/Patient Identifiers & Names.

938

3 AAA Error Code Reporting

939

3.1. Issue to be Addressed and Business Requirement Justification

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Healthcare providers and health plans have a requirement to uniquely identify patients (aka subscribers, members, beneficiaries) for the purpose of ascertaining the eligibility of the patient for health plan benefits. At a high level, this identification requirement consists of accurately matching:

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- Individuals with records and information that relate to them and to no one else; and
- Disparate records and information held in various organizations' computer systems about the same individuals.

946

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950

For health plans, this identification requirement currently is met by uniquely delineating the individuals whereby each person (or a subscriber and dependents) is assigned an identifier by the health plan covering the individual, i.e., a subscriber, member or beneficiary ID. This ID is combined with other demographic data about the individual (e.g., first name, last name, date of birth, gender, etc.) and then used in healthcare transactions, such as eligibility inquiries, claims submissions, etc.

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Healthcare providers obtain this unique identifier from patients, combine it with other demographic data, and then subsequently use it when conducting electronic transactions with health plans, such as insurance verification and claims submissions. The health plans (or information sources) then use this combination of ID and demographic data to attempt to uniquely locate the individual within their systems. However, oftentimes, the ID may not be valid and correct, the other demographic data submitted by the healthcare provider does not match similar demographic data held by the health plans' systems, or some of the data elements required by the health plan are missing; therefore such transactions are then rejected or denied.

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The v5010 270 transaction submitted by healthcare providers may contain some or all of the four data elements in the v5010 270/271 and agreed to in the trading partner agreements. §1.4.8 and §1.4.8.1 of the v5010 270/271 TR3 define a "maximum data set that an information source may require and identifies further elements the information source may use if they are provided. §1.4.8.2 defines four alternate search options that an Information Source is required to support in addition to the Primary Search Option. If an Information Source is unable to identify a unique individual in their system (more than one individual matches the information from the Required Alternate Search Option), the Information Source is required to reject the transaction and identify in the 2100C or 2100D AAA segment the additional information from the Primary Search Option that is needed to identify a unique individual in the Information Source's system."

969 Research conducted by CORE Participants indicated that improved specificity and standardized use of
970 the AAA codes would give providers better feedback to understand what information is missing or
971 incorrect in order to obtain a valid match.

972 **3.2. Scope**

973 **3.2.1. What the Rule Applies To**

974 This AAA error code reporting rule applies only to certain data elements used to identify a person in loops
975 and data segments in the v5010 270/271 TR3 as specified in §3.2.4 of this rule.

976 This rule defines a standard way to report errors that cause a health plan (or information source) not to be
977 able to respond with a v5010 271 showing eligibility information for the requested patient or subscriber.

978 The goal is to use a unique error code wherever possible for a given error condition so that the re-use of
979 the same error code is minimized. Where this is not possible, the goal (when re-using an error code) is to
980 return a unique combination of one or more AAA segments along with one or more of the submitted
981 patient identifying data elements such that the provider will be able to determine as precisely as possible
982 what data elements are in error and take the appropriate corrective action.

983 **3.2.2. When the Rule Applies**

984 This AAA error code reporting rule applies only when a health plan (or information source) is processing
985 the data elements identifying an individual in a v5010 270 received from a submitter and:

986 • The health plan (or information source) performs pre-query evaluation against one or more of the
987 HIPAA-maximum required data elements⁵ identifying an individual in a v5010 270 received from
988 a submitter.

989 Or

990 • The health plan (or information source) performs post-query evaluation against one or more of
991 the HIPAA-maximum required data elements identifying an individual in a v5010 270 from a
992 submitter.

993 In the context of this AAA error code reporting rule the following definitions will apply:

994 • Pre-query evaluation is the logic of one or more checks of the following done by a health plan's
995 (or information source's) system prior to a database look-up to determine if:

996 ○ The data elements it requires to identify an individual are present in the v5010 270

997 Or

998 ○ The data elements it requires to identify an individual satisfy formatting requirements as
999 defined in §3.3.3.2 of this rule.

1000 Or

1001 ○ The date-of-birth (DOB) for either the subscriber or dependent is a valid date as defined in
1002 §3.3.3.2 of this rule.

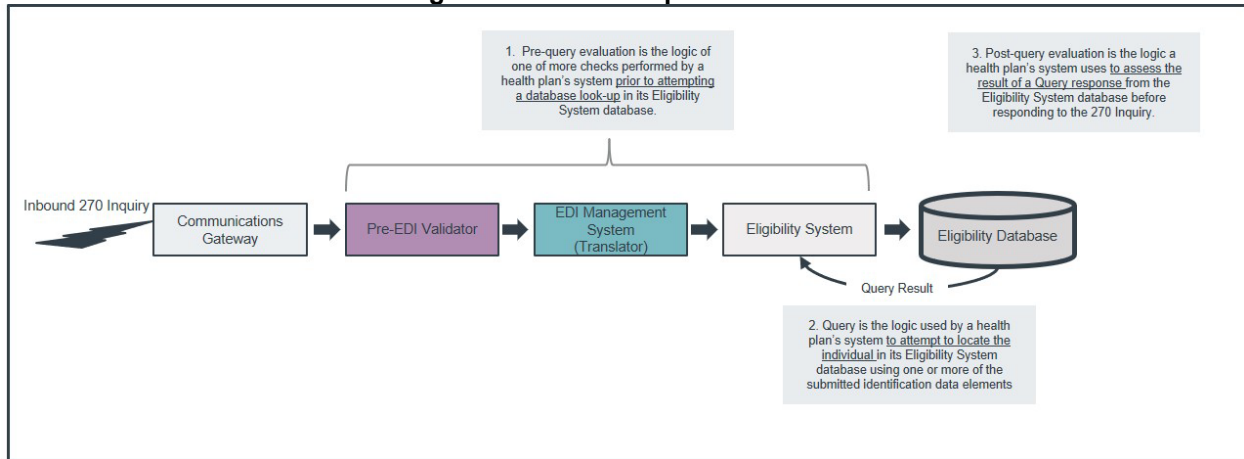
1003 **Query** is the logic used by a health plan's (or information source's) system to attempt to locate the
1004 individual in its eligibility system using one or more of the submitted identification data elements.

1005
1006 **Post-query** evaluation is the logic a health plan's (or information source's) eligibility system uses to
1007 assess the results of a Query attempt before responding to the v5010 270.
1008

⁵ HIPAA-adopted v5010 270/271 TR3 §1.3.8 through §1.4.8.1 specifies the following: "If the patient is the subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C are: Patient's Member ID, Patient's First Name, Patient's Last Name, Patient's Date of Birth. If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C and 2100D are: Loop 2100C Subscriber's Member ID, Loop 2100D Patient's First Name, Patient's Last Name, Patient's Date of Birth."

1009 Figure 3.2.2 below is a graphical representation of a conceptual system information flow showing where
 1010 such pre-query, query and post-query evaluations may take place. This diagram does not represent all
 1011 systems but is a conceptual approach solely to illustrate these concepts.
 1012
 1013

Figure 3.2.2 – Conceptual Information Flow



1014

3.2.3. What the Rule Does Not Require

1015

1016 This AAA error code reporting rule does not require a health plan (or information source):

- 1017 • to use any specific search and match criteria or logic
- 1018 • to use any specific combination of submitted identification data elements
- 1019 • to perform a pre-query evaluation
- 1020 • to perform DOB validation
- 1021 • to reject the v5010 270 upon detecting an error condition addressed by this rule, but only requires
- 1022 the health plan to return the AAA record when the health plan does reject the v5010 270.

3.2.4. Applicable Data Elements & Loops

1023

1024 This rule covers the following specified data element and loops in the v5010 270/271 transactions:

Loop ID and Name
Loop 2100C Subscriber Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
NM104-1036 First Name
NM108-66 ID Code Qualifier
NM109-67 ID Code
DMG02-1251 Subscriber Date of Birth
AAA01-1073 Valid Request Indicator
AAA03-901 Reject Reason Code
AAA04-889 Follow-up Action Code
Loop ID and Name
Loop 2100D Dependent Name
Data Element Segment Position, Number & Name
NM103-1035 Last Name
NM104-1036 First Name
DMG02-1251 Dependent Date of Birth
AAA01-1073 Valid Request Indicator
AAA03-901 Reject Reason Code
AAA04-889 Follow-up Action Code

1025

3.2.5. Assumptions

- 1026 • The v5010 270 and v5010 271 are compliant with v5010 270/271 TR3.
- 1027 • The submitter of the v5010 270 knows which data elements were submitted in the v5010 270
- 1028 (i.e., member identifier, first name, last name, date of birth).
- 1029 • A last or first name is considered invalid only when it does not match a last or first name in the
- 1030 health plan's (or information source's) eligibility system.

1031 **3.2.6. Abbreviations Used in this Rule**

- 1032 • MID = member identifier
- 1033 • FN = first name
- 1034 • LN = last name
- 1035 • DOB = date of birth

1036 **3.2.7. Outside the of Scope of this Rule**

1037 This rule does not specify whether or not a health plan (or information source) must use the full last or first
 1038 name or may use only a portion of the last or first name when performing a Pre-Query, Query, or Post-
 1039 Query process (refer to §2 for use of special characters and letter case in subscriber/patient names).

1040 **3.3. AAA Error Code Reporting Rule Requirements**

1041 **3.3.1. Basic Requirements for Health Plans and Information Sources**

1042 A health plan (or information source) is required:

- 1043 • To return a AAA segment for each error condition (as defined in the "Error Condition Description"
- 1044 column of the Error Reporting Codes & Requirements Table in §3.3.5) that it detects as specified
- 1045 in §3.3.3 – 3.3.5
- 1046 And
- 1047 • To return code "N" in the AAA01 Valid Request Indicator data element
- 1048 And
- 1049 • To return the specified Reject Reason Code in AAA03 as specified in §3.3.3 – 3.3.5 for the
- 1050 specific error condition described
- 1051 And
- 1052 • To return code "C" in the AAA04 Follow-up Action Code data element
- 1053 And
- 1054 • To return data elements submitted and used as specified in §3.3.5.

1055 This may result in multiple AAA segments being returned in the v5010 271 response such as a AAA
 1056 segment specifying an error in the LN data element and another AAA segment specifying an error in the
 1057 MID data element in the same NM1 segment. Examples of such AAA segments include (error conditions
 1058 and required error codes are specified in subsequent sections of this rule):

- AAA*N**73*C~ Indicates LN missing & required or LN does not match LN in eligibility system
- AAA*N**73*C~ Indicates FN missing & required or FN does not match FN in eligibility system
- AAA*N**72*C~ Indicates MID missing & required or MID does not match MID in eligibility system

1059 **3.3.2. Basic Requirements for Receivers of the v5010 271**

1060 The receiver of a v5010 271 (defined in the context of this rule as the system originating the v5010 270) is
 1061 required:

- 1062 • To detect all combinations of error conditions from the AAA segments in the v5010 271 as
- 1063 defined in the "Error Condition Description" column of the Error Reporting Codes & Requirements
- 1064 Table in §3.3.5
- 1065 And

- 1066 • To detect all data elements to which this rule applies as returned by the health plan in the v5010
1067 271
- 1068 And
- 1069 • To display to the end user text that uniquely describes the specific error condition(s) and data
1070 elements returned by the health plan in the v5010 271
- 1071 And
- 1072 • Ensure that the actual wording of the text displayed accurately represents the AAA03 error code
1073 and the corresponding “Error Condition Description” specified in the Error Reporting Codes &
1074 Requirements Table in §3.3.3 – 3.3.5 without changing the meaning and intent of the error
1075 condition description.

1076 The actual wording of the text displayed is at the discretion of the receiver.

1077 **3.3.3. Pre-Query Error Conditions and Reporting Requirements**

1078 Pre-query errors may occur when a health plan (or information source) performs various evaluations
1079 against the data elements in the v5010 270 used to identify an individual. There are two types of pre-
1080 query evaluations that may be performed as specified in §3.3.3.1 and §3.3.3.2.
1081 A health plan (or information source) is not required by this rule to perform any pre-query evaluations.
1082 When a health plan (or information source) performs a pre-query evaluation, it must return a AAA
1083 segment for each error condition detected along with the data elements submitted and used as specified
1084 in §3.3.3.1 and §3.3.3.2.

1085 **3.3.3.1. Missing & Required Data Element**

1086 This error condition may occur when a health plan (or information source) checks to determine that one or
1087 more of the data elements it requires to attempt a database look-up in its eligibility system are present in
1088 the submitted v5010 270.
1089 When a health plan (or information source) checks for missing and required data elements and errors are
1090 found, the health plan (or information source) is required to return a v5010 271 as specified in §3.3.5 of
1091 this rule.
1092 This rule does not require a health plan (or information source) to check for missing and required data
1093 elements.
1094 The maximum data elements that may be required by a health plan (or information source) are specified
1095 in §1.4.8 Search Options of the v5010 270/271 TR3.

1096 **3.3.3.2. Invalid MID or DOB**

1097 An invalid MID error condition may occur when a health plan (or information source) has specific
1098 requirements for the minimum or maximum length or datatype (e.g., all numeric) of a member identifier.
1099 This rule does not require a health plan (or information source) to validate a MID for any formatting
1100 requirements.
1101 The MID is invalid if it does not meet either the length, formatting or data type requirements of the health
1102 plan. When a health plan (or information source) checks the format of the MID and the MID is invalid, the
1103 health plan (or information source) must return a v5010 271 as specified in §3.3.5 of this rule.
1104 An invalid DOB error condition may occur when a health plan (or information source) validates a DOB.
1105 This rule does not require a health plan (or information source) to validate a DOB.
1106 A DOB is invalid when it does not represent a valid date as determined by the health plan (or information
1107 source).
1108 When a health plan (or information source) validates a DOB and errors are found, the health plan (or
1109 information source) is required to return a v5010 271 as specified in §3.3.5 of this rule.

1110 **3.3.3.3. Pre-Query Error Reporting**

1111 When a pre-query error is detected the health plan (or information source) must

- 1112 • Return a AAA segment for each error detected using the appropriate Reject Reason Code for
1113 each Pre-Query Error Condition listed in §3.3.5 of this rule

- 1114 And
- 1115 • Return the data elements indicated in §3.3.5 of this rule.

1116 **3.3.4. Post-Query Error Conditions and Reporting Requirements**

1117 Post-query errors may occur when a health plan (or information source) attempts a database look-up in
 1118 its eligibility system and is not able to locate a unique record. The following types of post-query errors that
 1119 may occur include:

- 1120 • Look-up attempted, no record found
- 1121 • Look-up attempted, single record found
- 1122 • Look-up attempted, multiple records found

1123 The error conditions and error codes reporting requirements tables specified in §3.3.5 of this rule are
 1124 designed to apply regardless of a health plan’s (or information source’s) specific search and match logic.
 1125 As such, the codes are applicable to any health plan’s (or information source’s) search and match logic.
 1126 A health plan (or information source) is not required by this rule to use any specific combination of
 1127 submitted individual identification data elements nor any specific search and match logic.

1128 When a health plan (or information source) detects any of the specified error conditions, it must

- 1129 • Return a AAA segment for each error detected using the appropriate Reject Reason Code for
 1130 each Post-Query Error Condition as specified in §3.3.5 of this rule

1131 And

- 1132 • Return the data elements as specified in §3.3.5 of this rule.

1133 **3.3.5. Error Reporting Codes & Requirements Table**

1134 The Error Reporting Codes and Requirements Table below describes each error condition and the
 1135 corresponding AAA03 error code that must be used to identify the error in the v5010 271. Errors may
 1136 occur in either the Subscriber Loop or the Dependent Loop or both. The error code that must be used for
 1137 each defined error condition is marked with an X. The data elements submitted in the v5010 270 that
 1138 must be returned if used are also specified. Multiple error conditions are possible.

Table 3.3.5: Error Reporting Codes & Requirements Table

Error Reporting Codes & Requirements Table											
		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
Pre-Query - No Look-up Attempted Missing & Required Data											
1	Health plan (or information source) requires MID MID was not submitted in the v5010 270			X			None				

Error Reporting Codes & Requirements Table

		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
	Health plan (or information source) does not attempt look-up										
2	Health plan requires LN LN was not submitted in the v5010 270 Health plan does not attempt look-up				X		None		X		None
3	Health plan (or information source) requires FN FN was not submitted in the v5010 270 Health plan (or information source) does not attempt look-up				X		None		X		None
4	Health plan (or information source) requires DOB DOB was not submitted in the v5010 270 Health plan (or information source) does not attempt look-up	X					None	X			None

Error Reporting Codes & Requirements Table

		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
Pre-Query – No Look-up Attempted Formatting Errors											
5	MID submitted in the v5010 270 does not satisfy health plan (or information source) formatting requirements Health plan (or information source) does not attempt look-up			X			MID submitted				
6	DOB submitted is not valid Health plan (or information source) does not attempt look-up	X					Subscriber DOB submitted	X			DOB submitted at either Subscriber or Dependent Level or both depending on which DOB is in error
Post-Query – Look-up Attempted No Record Found											
7	MID submitted in the v5010 270 in Subscriber loop is not found in eligibility system when health plan (or information source) uses MID to search			X			Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements				

Error Reporting Codes & Requirements Table

		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
8	LN submitted in the v5010 270 in Subscriber loop is not found in eligibility system when health plan (or information source) uses LN to search				X		Subscriber LN submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
Post-Query – Look-up Attempted Single Record Found											
9	MID submitted in the v5010 270 in Subscriber loop does not match MID in eligibility system when health plan (or information source) uses LN to search and a single record is returned			X			Subscriber MID submitted Subscriber LN submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
10	LN submitted in the v5010 270 in Subscriber or Dependent loop does not match LN in eligibility system when health plan (or information source) uses MID to search and a single record is returned				X		Subscriber MID submitted Subscriber LN submitted Other data elements submitted & used		X		None
11	FN submitted in the v5010				X		Subscriber FN submitted		X		Dependent FN submitted

Error Reporting Codes & Requirements Table

		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
	270 in either Subscriber or Dependent loop does not match FN in eligibility system when health plan (or information source) uses either MID or LN to search and a single record is returned						Other data elements submitted & used and any AAA error codes associated with these data elements				Other data elements submitted & used and any AAA error codes associated with these data elements
12	DOB submitted in the v5010 270 in either Subscriber or Dependent loop does not match DOB in eligibility system when health plan (or information source) uses either MID or LN to search and a single record is returned		X				Subscriber DOB submitted Other data elements submitted & used and any AAA error codes associated with these data elements			X	Dependent DOB submitted Other data elements submitted & used and any AAA error codes associated with these data elements

Error Reporting Codes & Requirements Table

		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
13	LN and/or FN submitted in the v5010 270 in Dependent loop does not match LN and/or FN in eligibility system when health plan (or information source) uses MID to search and a single record is returned <i>Note: This may be an unlikely condition that could occur, e.g., a MID only submitted in Subscriber loop and Dependent LN submitted</i>								X		Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements
Post-Query Look-up Multiple Records Found											
14	Multiple records returned when only a MID submitted in the v5010 270 in Subscriber loop (MID search)					X	Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
15	Multiple records returned for LN when only LN/FN was submitted in the v5010 270				X		Subscriber LN submitted Other data elements submitted & used and any AAA				

Error Reporting Codes & Requirements Table

		Subscriber Loop						Dependent Loop			
Error Condition #	Error Condition Description	Invalid/Missing Date-of-Birth	Patient Birth Date Does Not Match That for the Patient in the Database	Invalid/Missing Subscriber/Insured ID	Invalid/Missing Subscriber/Insured Name	Duplicate Subscriber/Insured ID	Data Elements Returned in 271 Response (See Note 1)	Invalid/Missing Date-of-Birth	Invalid/Missing Patient Name	Patient Birth Date Does Not Match That for the Patient in the Database	Data Elements Returned in 271 Response (See Note 1)
		58	71	72	73	76		58	65	71	
	in Subscriber loop (name search)						error codes associated with these data elements				
16	LN submitted in the v5010 270 in Subscriber loop does not match LN in eligibility system when only LN/MID was submitted and health plan (or information source) uses MID to search and multiple records are returned				X		Subscriber LN submitted Subscriber MID submitted Other data elements submitted & used and any AAA error codes associated with these data elements				
17	FN submitted in the v5010 270 in Subscriber loop does not match FN in eligibility system when only FN/ LN/MID was submitted and health plan (or information source) uses either MID or LN to search and multiple records are returned				X		Subscriber FN submitted Other data elements submitted & used and any AAA error codes associated with these data elements				

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1142 4 Conformance Requirements

1143 Conformance with this CORE Operating Rule can be voluntarily demonstrated and certified through
 1144 successful completion of the Eligibility & Benefits CAQH Certification Test Suite with a third party CORE-
 1145 authorized Testing Vendor, followed by the entity's successful application for a CORE Certification Seal.

CAQH Committee on Operating Rules for Information Exchange (CORE)
Eligibility & Benefits (270/271) Data Content Rule vEB.2.0
Draft for Final CORE Vote

1146 A CORE Certification Seal demonstrates that an entity has successfully tested for conformity with all the
1147 CORE Eligibility & Benefits Operating Rules, and the entity or its product has fulfilled all relevant
1148 conformance.

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