



ALASKA MEDICAL ASSISTANCE
270/271 Eligibility Benefit Inquiry and Response Transaction



270/271 Eligibility Benefit Inquiry and Response Transactions

Overview of 5010 changes



[Title slide only.]



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Welcome



Thank you for attending this webinar session on 5010 changes to the 270 Eligibility Benefit Inquiry and 271 Response transactions. [Introduce self.] I would also like to introduce our Subject Matter Experts. [Introduce SMEs.] At the end of this webinar, they can help answer questions you may have, so be sure to write down your questions as we go along. A copy of today's presentation will be published on medicaidalaska.com. Let's get started.



Overview

- Effective January 1, 2012
- Changing from 4010 to 5010
- Alaska-specific information
- 5010 Companion Guides
- 5010 Technical Reports Type 3 (TR3s)

As you already know, changes to electronic transaction formats will be effective January 1, 2012, and we want you to be aware and ready for the implementation of the federally-mandated HIPAA changes. All HIPAA-covered entities must convert from HIPAA X12 Version 4010A1 electronic transaction standard to the new Version 5010. HIPAA-covered entities are our trading partners, which includes providers, clearinghouses, and health plans.

During this webinar, we will go over some of the 5010 changes that you may need to know. Mostly we will review information that is Alaska Medical Assistance-specific. You will learn what to expect in the 5010 formats as it applies to your interactions with us.

The information we will discuss is not a step-by-step guide on completing electronic transactions. It is an introduction to things you should pay attention to in your 5010 Companion Guide and TR3, which stands for Technical Report Type 3. These documents provide thorough information about the mandated HIPAA changes. TR3s are developed and approved by the ASC X12 committee which is part of the American National Standards Institute, or ANSI. The federal Department of Health and Human Services Centers for Medicare and Medicaid Services, known as CMS, passes regulations to enforce use of these transaction standards. They give you technical details on how the electronic transactions need to be formatted. Each electronic format has its own TR3. You can purchase them from Washington Publishing Company. Trading partners, which includes providers, must adhere to the most current TR3s. ACS published the Alaska Medical Assistance version of the 5010 Companion Guide.



Learning Objectives

- Identify general changes to electronic transactions
- Summarize specific changes that impact providers
- Discuss unique requirements for Alaska Medicaid
- Describe the new 999 transaction
- Identify available resources

This webinar will cover the objectives listed on the screen. Everything we discuss is meant to give you a better understanding of the changes in 5010 – from submitting your 270 Eligibility Benefit Inquiry transaction to receiving your 271 Response to dealing with errors. Some changes apply to all electronic transactions. Other changes relate specifically to a particular format, such as the 270 and 271. And then there are changes that are unique requirements for Alaska Medicaid. These Alaska-specific changes are documented in the 5010 Companion Guides.




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General 5010 Information



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Why Change to 5010?

- New version federally mandated
- Improves standards for administrative simplification
- Corrects problems in 4010
- Creates better access to health insurance
- Limits fraud and abuse
- Reduces administrative costs
- Supports ICD-10 (October 2013)



You may be wondering, “Why are we changing from 4010 to 5010?” The short and simple answer is that it is law. We must do it.

ANSI, which I mentioned earlier and is the acronym for the American National Standards Institute, originally implemented transaction standards referred to as 4010 in 2003 and CMS mandated the ANSI 4010 standards. However, numerous deficiencies and inconsistencies have been identified since 4010 was implemented. As a result, ANSI updated the electronic transmission standards to improve the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. ANSI ensured that 5010 corrected these problems.

CMS is mandating the 5010 electronic transmission standards effective January 1, 2012. By using these standards, CMS is able to create better access to health insurance, limit fraud and abuse, and reduce administrative costs. The 5010 changes are also a critical step in preparing for the implementation of ICD-10 that is planned for October 2013.

Just to be clear, as of January 1, 2012, we will no longer accept 4010 transactions.

Now we are going to review some of the common changes that apply to all parts of 5010. The changes you are about to see impact everything from 270s and 999s to CMS requirements to Alaska Medicaid requirements.



Universal 5010 Changes

- Field sizes increased
- Some loops, segments, and elements are unused

The changes you see on this slide apply throughout both the 270 and 271 transactions.

One of the most common changes for 5010 is that many of the fields have increased in size. For example, the first name and last name for providers, clients, payers, etc. increased to 35 and 60 characters, respectively. Certain identifiers such as medical record numbers and referral numbers increased to 50 characters. Alaska Medical Assistance will accept and return these expanded field values. At the present time, however, we will continue to use current field sizes internally for processing claims.

You may see references to loops, segments, and elements throughout this webinar. These are components of electronic transactions. Information about them can be found in the Companion Guides and on our website. All of the unused components are documented in the Companion Guide if you want even more detailed information.



Alaska-Specific Requirements

- Narrower subsets of codes
- Information exclusive to Alaska Medical Assistance
- Found in 5010 Companion Guides

http://medicaidalaska.com/providers/hipaa/hipaa5010Companion_Guides.shtml

- Supplemented by TR3 <http://store.x12.org/store/>

Now that we have reviewed some general information about the new 5010 transactions, we are ready to discuss some Alaska-specific things. We'll start with the 270 and then move on to the 271 and error reports. What we are about to review from this point on will be helpful for you only if you submit transactions to or receive transactions from Alaska Medical Assistance. The changes we are going to look at help you decipher the meaning of the codes you could receive.

Remember to refer to your Companion Guides for information about Alaska Medical Assistance-specific 5010 transactions. Since we have mentioned the Companion Guides several times now, we have included the link on the screen where you can go to get them. They are available free-of-charge for you to review and print. If you need more information about Companion Guides, please refer to the 5010 Companion Guide webinar. You will need to supplement the Companion Guides with the TR3s. That link is listed on the screen as well.




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Information about 270 Eligibility Benefit Inquiry and 271 Response



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270 Eligibility Benefit Inquiry and 271 Response Transaction

- Transaction pair
- 270: Requests information
- 271: Returns information
- Specified by ANSI and required by HIPAA
- Secure transactions



Now we are ready to go over some of the changes that are specific to understanding the 270 and 271 transactions.

The 270/271 is a paired transaction set comprised of 2 transactions: the 270 is used to request or inquire information, and the 271 is used to respond with coverage, eligibility, and benefit information. Although the 270 can be used to verify benefits and eligibility, it can not provide a history of benefit use. Likewise, the 271 response delivers a lot more information than, "Yes, the recipient is eligible today," such as plan beginning and ending dates.

ANSI dictates the format you must use to submit eligibility inquiries electronically. These transactions come to ACS who processes your information requests on behalf of the Alaska Medical Assistance Program.

Alaska Medical Assistance requires a secure method of transferring files. You must have a File Transfer Protocol (FTP) server with a Secure Shell (SSH) connection to ensure that user login and data transmission meet HIPAA privacy and security requirements. All electronic files sent to and received from ACS must utilize this SSH FTP connection and must be in the HIPAA compliant format (5010). The login to the Secure File Transfer Protocol (SFTP) server is encrypted as is the actual transferring of files to and from the client and server. You can rest assured that patient information transferred over the Internet or with a Dial-Up connection using this protocol is secure and meets HIPAA requirements.

As we mentioned earlier, there are many 5010 changes to the 270 and 271 transactions. Let's begin now going over some of the most important ones.



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Information about 270



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General 270 Changes

- Continued availability of Eligibility Verification System (EVS)
- Member/Recipient Medicaid ID number
- Flexibility of patient information

All 270 transactions will be treated as inquiry transactions.

It is very important to remember that you can still call the Eligibility Verification system (EVS) to obtain the information you are currently receiving. It is not going away as a resource.

Alaska Medicaid will be requiring the recipient's Alaska Medicaid ID number for all 270 benefit/eligibility inquiry transactions.

If a unique individual cannot be identified in our database, the provider/trading partner will receive a 271 response that will include a 2100C AAA segment with a code that explains specifically why the 270 Eligibility Request was not processed.



Search Options for 270

Primary search option:

- Recipient's Alaska Medicaid ID
- Recipient's first name
- Recipient's last name
- Recipient's date of birth

The Primary Search Option for identifying a patient/recipient in Loop 2100C is to use all four of these items: Recipient's ID, Recipient's First name, Recipient's Last Name, and Recipient's Date of birth. If all four of these elements are present, then AK Medical Assistance must generate a response if the recipient is in the database. If the provider does not have all four of these data elements for a recipient, you can submit one of the HIPAA-required alternate search options, which AK Medical Assistance uses to search for a recipient in their system:

1. Recipient ID, Date of Birth, and Last Name
2. Recipient ID, First Name, and Last Name

If a unique match for an individual is made, then Alaska Medical Assistance returns information from that individual's record. If the provider does not have enough data on a recipient to use the Primary or Alternate Search options above, Alaska Medicaid will not be able to process the request.



270 Specific Changes

Field and Code Descriptions		
Element	Name	Details
HDR BHT06	Transaction Type Code	Spend Down restriction
2100B NM101	Entity Identifier Code of the Information Receiver	1P = Provider 80 = Hospital FA = Facility
2100B NM108	Identification Code Qualifier	XX = NPI SV = Service Provider Number
2100B REF01	Reference Identification Qualifier	1D = Medicaid Provider Number

The next two charts provide detailed information about the fields and codes that are unique to the Alaska Medicaid program when submitting 270 eligibility benefit inquiries. In all the charts you see throughout this webinar, the first column refers to the specific field name in the transaction. The second column states what that field is commonly referred to as, and the last column shows what valid values Alaska Medicaid accepts in the field and gives you any special instructions. In many instances, Alaska does not use all the codes specified in the TR3 so it is important to refer to Alaska Medicaid's 5010 Companion Guides to determine what is acceptable.

Alaska Medicaid does not support additional functionality for Spend Down. If it is sent, it will not be used for processing the inquiry.

For the Information Receiver Name segment, Alaska recommends that providers only use the following codes for the Entity Identifier element NM101: 1P for provider, 80 for hospital, and FA for facility.

For the Identification Code Qualifier, Alaska is requesting that providers send XX for NPI. If the provider is an atypical provider who does not have an NPI, then send SV for Service Provider number.

For the Reference Identification Qualifier in the Information Receiver Additional Identification segment, Alaska requests that the provider send the qualifier '1D' for Medicaid ID if the provider is an atypical provider (who does not have an NPI to submit in 2100B NM108).



270 Specific Changes

Field and Code Descriptions		
Element	Name	Details
2100C REF01	Reference identification Qualifier	SY = Social Security Number
2100C DTP01	Date/Time Qualifier	291
2100C DTP02	Date Time Period Qualifier	D8 = Date CCYYMMDD RD8 = Range of Dates CCYYMMDD-CCYYMMDD
2100C DTP03	Date Time Period	Enter a date or range of dates
2110C EQ01	Service Type Code	30 = Health Benefit Plan Coverage

The recipient's Social Security Number is the preferred additional identification number.

The 307 qualifier is no longer a valid value in the date/time qualifier field. Alaska Medical Assistance supports use of value 291 in this field.

For the Date Time Period, you can enter a date or a range of dates.

At this time, the Alaska Medicaid system will support the generic request for eligibility, which is Service Type Code "30". If a different Service Type Code is submitted to Alaska, such as 1-Medical Care, 2-Surgical, 3-Consultation, 4-Diagnostic X-ray, etc., Alaska will return a generic response in the 271. This is the same response Alaska will return if a Service Type Code of "30" is submitted. We will discuss the 271 generic response AK will return in a moment.




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Information about 271



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General 271 Highlights

- Effective date on the response
- New date qualifiers
- Multiple eligibility dates
- Third Party Liability (TPL) information changes
- Return of additional recipient benefit information



The 271 transaction is the response to the 270 inquiry transaction.

When a match is found in our database to information on the inquiry, the 271 will report specific Alaska Medicaid recipient eligibility information. The 271 response defaults to information that is in effect on the date the transaction is processed, unless a specific date or range of dates is submitted on the request.

New date qualifiers have been added to support returning requested date range information. When a specific date range is requested, the response may include more than one segment of active eligibility to encompass the date range requested. For example, the inquiry may specify a two-month time period. It is possible the recipient may have different types of Alaska Medical Assistance eligibility for each month specified. The recipient may have CAMA eligibility in one month but have general Medicaid eligibility the following month. At times, you may receive a response with instructions to contact our offices. This may occur in situations where eligibility restrictions exist.

Version 5010 requires additional benefit information to be returned in the form of service type codes. This will be discussed in detail in the next slide.

In addition to Medicaid eligibility information, we will also be returning limited third party insurance information. The Third Party Liability (TPL) carrier name and associated dates will be returned, but coverage details will not. TPL policy identification numbers and group numbers will no longer be provided. Medicare coverage information reported will consist of only the Medicare type code A, B, or D and associated dates. HIC#'s will no longer be reported.



General 271 Highlights

Service type coverage codes returned (2110C EB03)

Code	Description	Code	Description
1	Medical Care	88	Pharmacy
33	Chiropractic	98	Professional (Physician) Visit - Office
35	Dental Care	AL	Vision (Optometry)
47	Hospital	MH	Mental Health
86	Emergency Services	UC	Urgent Care

In response to a 270 eligibility inquiry, the subscriber eligibility or benefit information (EB) loop repeats as needed to convey the Alaska Medical Assistance eligibility detail. In addition, a set of up to 10 service type codes will be returned. These are national codes that communicate broad benefit coverage information. The codes are displayed in the slide and are as follows:

- 1: Medical Care
- 33: Chiropractic Care
- 35: Dental Care
- 47: Hospital Services
- 86: Emergency Services
- 88: Pharmacy
- 98: Professional (Physician) Visit – Office
- AL: Vision (Optometry)
- MH: Mental Health
- UC: Urgent Care

There are many more service type code components within each of these broad category codes, but Alaska Medical Assistance will not be reporting that level of detail. Note that the service type component of infertility is excluded from coverage when Medical Care (service type code 1) is included in the Alaska Medical Assistance response. This is because Alaska Medical Assistance regulations do not permit coverage for infertility services. Please remember that Alaska Medical Assistance regulations and service coverage policies define the coverage details governing these broad national benefit coverage categories.

When recipient eligibility codes are 19, 21 or 25, as reported in the EB05 element (field), benefits are restricted to consultation and diagnostic medical services when the Medical Care service type is returned. You can find more details about eligibility codes in the provider billing manuals. These are located on the medicaidalaska.com website.

The above benefit plan information will be returned in the EB03 element when the value in the EB04 element is MC for Medicaid. Additional information about the EB04 will be presented in a subsequent slide.



271 Specific Highlights

Field and Code Descriptions		
Element	Name	Details
2100C NM1	Subscriber Name	Reflect the values received in the 270.
2100C NM109	Subscriber Primary Identifier	Recipient ID number will be returned as it was received in the 270 transaction.
2100C REF02	Subscriber Supplemental Identifier	Value reported is same as in the 270

In order to secure the confidentiality of our recipient records, Alaska Medical Assistance will only return the recipient identifier information received on the inquiry. The information in this slide highlights some key recipient identifiers: recipient name, recipient identification number and recipient social security number. The value submitted on the inquiry (270) for each of these will be returned on the response (271). Note that the Recipient ID Number (NM109) is the primary match criteria for locating records in our files.



271 Specific Highlights

Field and Code Descriptions		
Element	Name	Details
2110C EB04	Insurance Type Code	MC = Medicaid LC = Long Term Care MA = Medicare Part A MB = Medicare Part B OT = Other
2120C NM101	Entity Identifier Code	P3 = Lock In Primary Care Provider FA = Long Term Care Facility
2120C NM108	Identification Code Qualifier	XX = Lock in Provider NPI

If applicable to a recipient, additional eligibility information may be provided. This may include Medicare Part A, B or D, Third Party insurance, Long Term Care, or Lock In information. As mentioned earlier, Medicare coverage information reported will consist of only the Medicare type code A, B, or D and associated dates. HIC#'s will no longer be reported. EB04 value OT for "Other" is used to return applicable Medicare Part D information. In addition, when applicable to the recipient, Third Party insurance and Lock In information will be returned with EB04 value of OT for "Other". Information contained in the EB05 element will communicate whether the OT information returned in the EB04 represents Medicare Part D, TPL, or Lock In data.

When long term care authorization or lock-in restrictions exist for a recipient, Alaska Medical Assistance will return the name of the applicable Long Term Care facility or the Lock In provider name. Information in the NM101 will communicate whether a Long Term Care facility name or a Lock in provider name is being returned. Additionally, the NPI number will be returned for a Lock In provider.



271 Specific Highlights

Field and Code Descriptions		
Element	Name	Details
2000A AAA	Request Validation	Inquiries that exceed 99 patient requests will not receive a 271 AAA response.
2100A AAA03	Reject Reason Code	79 = Invalid Submitter ID
2100B AAA03	Reject Reason Code	43 = Invalid/Missing Provider Identification 51 = Provider Not on File

Prior slides have presented details about the response information you will receive when a match is made to a recipient record on our database. The next two slides will discuss the type of information returned when an error occurs.

Inquiry transactions that exceed 99 patient requests will reject immediately with a negative 999. No 271 transaction will be returned.

A '79' is returned if the Alaska Medical Assistance Submitter ID is invalid or the Application Receiver Code is not '77200'.

This slide highlights two possible reasons for receiving a provider-related reject. Invalid or missing provider identification information on your inquiry will result in a reject reason code 43. If the provider is not on our files, a reject reason code 51 will result. The loop and element where this information is stored is shown in the slide.



271 Specific Highlights

Field and Code Descriptions		
Element	Name	Details
2100C AAA03	Reject Reason Code	42 = Unable to Process 52 = Provider not Enrolled 58 = Missing Date of Birth 61 = DOD precedes DOS 71 = DOB does not Match 72 = Recipient SSN not Found 73 = Name does not Match 75 = Recipient ID not Found 76 = Last Name & DOB search returned more than 1 match

There are additional reasons why an inquiry is unable to process successfully. Codes in this slide may indicate problems with the system, the application, or the data content.

A '42' will be returned if the system files are closed or unable to process. The provider/trading partner should resend their request.

A '52' will be returned if the provider was not enrolled for the dates requested in the 270.

A '58' will be returned if the 270 Request is missing Date of Birth.

A '61' will be returned if the patient Date of Death submitted in the 270 Request precedes the date(s) of service. -

A '71' will be returned if the patient date of birth submitted in the 270 Request does not match that on the Alaska Medical Assistance System Recipient file.

A '72' will be returned if the Recipient SSN number was not found on the Alaska Medical Assistance System Recipient file.

A '73' will be returned if the Recipient Name reported in the (Subscriber/Insured name) 270 Request does not match exactly with one unique Recipient in the Alaska Medical Assistance System Recipient file.

A '75' will be returned if the Recipient number was not found on the Alaska Medical Assistance System Recipient file.

A '76' will be returned if the Recipient's last name and date of birth search returns more than one match.



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Information about Transaction Failures



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Acknowledgements

- TA1
 - Interchange acknowledgement
 - Negative means received with an error
- 999
 - Implementation acknowledgement
 - 999s are the new 997s
 - Rejected 999
 - Accepted with errors 999

If your 270 benefit/eligibility request transmission does not go through or has problems, you will be notified.

If there are problems with your submission, you will receive a TA1 or 999.

If your submission was successfully received you will get a 999.

These will detail accepted or rejected claims.

The 5010 999 error report replaced the 4010 997 error report.



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999 Error Reports

```
HI^BK:V016~  
REN*E1*521212121~  
IY*1..
```

REN is an invalid segment identifier

The 4010 997 error report is replaced in 5010 with the 999 error report.



999 error reports show up under your file rejection claims. Many times providers look at the reasons the claim was returned and not the codes. Looking at the reasons is fine. They give you a good understanding of what you need to do to fix the problem. However, if you want to dig a little deeper, you may want to look at the codes.

In a case where the header, submitter, receiver, provider, and subscriber loops are all valid, but an error occurs in a single claim, only the claim containing the error is rejected.

On the screen, you see an example of a claim-level error as it appears in the 999 error report. Notice that the boxed and bolded segment **REN** was submitted, but it is not a valid segment identifier. Perhaps, the trading partner meant REF? REN would be rejected, but everything above it would be passed on for processing.



Samples of New 999 Details

IK304 Segment Syntax Error Code	Element Syntax Error Code
1. Unrecognized Segment ID	1. Required Data Element Missing
2. Unexpected segment	2. Conditional Required data Element Missing
3. Required Segment Missing	3. Too Many Data Elements
4. Loop Occurs Over Maximum Times	4. Data Element Too Short
5. Segment Exceeds Maximum Use	5. Data Element Too Long
6. Segment Not in Defined Transaction Set	6. Invalid Character in Data Element
7. Segment Not in proper Sequence	7. Invalid Code Value
8. Segment Has Data Element Errors	8. Invalid Date
14. Implementation "Not Used" Segment Present	9. Invalid Time
16. Implementation Dependent Segment Missing	10. Exclusion Conditional Violated.
17. Implementation Loop Occurs Under Minimum Times	12. Too Many Repetitions
18. Implementation Segment Below Minimum Use	13. Too Many Components
19. Implementation Dependent "Not Used" Segment Present	110. Implementation "Not Used" Data Element Present.
	111. Implementation Too Few Repetitions
	112. Implementation Pattern Match Failure
	113. Implementation Dependent "Not Used" Data Element Present
	16. Code Value Not Used in Implementation
	Implementation Dependent Data Element Missing.

New error code values

NOTE: Codes highlighted in red or blue are new for 5010

NOTE: The 999 utilizes IK and CTX segments where the 997 did not

In the 999 error reports, you may notice some new codes. Note that there is additional information both at the segment and the element level. The segment syntax errors are in red in the image on the screen and the element syntax errors are in blue. The entire list of error codes can be found in the 999 TR3.

In the left column, you can see some of the IK304 segment syntax error codes. 1 - 8 are codes that were in 4010 error reports and may still apply to your claims in 5010. However, there are some new codes and you can see samples of those listed in red. Some of the new codes include 14 and 16 – 19. In the right column, you can see some of the element syntax error codes. Again, the codes in black are codes that you may already be familiar with. But the codes in blue, in this case 12, 13, I10 – I13, 16, and 19, are new.



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270/271 Webinar Wrap-Up



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Questions?

- Ask a subject matter expert
- Email AKHIPAASupport@acs-inc.com
- Call
 - Toll-free at 855-226-9391
 - Local Alaska number at 907-644-6831
- Go to www.medicaidalaska.com
- Subscribe to the RSS feed

Now we'd like to give you an opportunity to ask any questions you might have about 5010. Remember, a subject matter expert is on this call to help answer your specific or technical questions. Does anybody have any questions?

[Wait for Q&A to conclude.] Be sure to write down the contact information on the screen so you know who to contact if you think of other questions about 5010. You can also subscribe to our RSS feed to get information sent automatically to you anytime something new is posted on our website.



Other 5010 Courses

- Companion Guides and Testing Requirements
- 837P Professional Claim Transaction
- 837I Institutional Claim Transaction
- 837D Dental Claim Transaction
- 837P Atypical Professional Claim Transaction
- PayerPath Changes

As we've gone through the changes in the 270 and 271 transactions, and the error reports and as we've taken your questions, you may have realized that you would like to learn more about 5010. If that is the case, we have several training opportunities available, and we encourage you to take advantage of them. You can register for these other webinars by going to our website at www.medicaidalaska.com. Like all Alaska Medical Assistance training presentations, the 5010 presentations will be posted to the website for provider reference to view at your convenience.



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Thank You



Thank you for your attendance to this webinar. And remember, if you'd like to review this webinar, you can. It will be published on the medicaidalaska.com website within the next few days. Have a great day.