



UnitedHealth GroupSM

Standard Companion Guide

**Refers to the Implementation Guide Based
on X12 Version 004010A1
Eligibility Inquiry and Response
(270/271)**

Companion Guide Version Number: 2.0

November 2008

Change Log

<i>Version</i>	<i>Release date</i>	<i>Changes</i>
2.0	11/10/2008	Initial External Release – Changes to comply with MN 62J (Eligibility Transaction Requirements) This functionality is planned for December, 2008. Effective date will be communicated separately in a release notice.

Preface

This Companion Guide to the ASC X12N Implementation Guide clarifies and specifies the data content when exchanging electronically with UnitedHealthcare. Transmissions based on this companion guide, used in tandem with the specified X12N Implementation Guides, are compliant with both X12N syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N implementation Guides. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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1. INTRODUCTION

1.1. SCOPE

This guide is to be used for the development of the 270/271 0004010 Eligibility Inquiry and Response transaction for the purpose of attaining a member's eligibility and benefits from UnitedHealthcare.

1.2. OVERVIEW

This Companion Guide will replace, in total, the previous UnitedHealth Group Companion Guide for Eligibility Inquiry and Response, including the latest release dated August, 2008 and all previous releases.

This UnitedHealthcare Eligibility Inquiry and Response Companion Guide has been written to assist you in designing and implementing Eligibility transactions to meet UnitedHealthcare's processing standards. This Companion Guide must be used in conjunction with the Eligibility Inquiry and Response (270/271) instructions as set forth by the ASC X12 Standards for Electronic Data Interchange Addenda A1 (Version 004010X092A1), March 2003 (referred to hereafter as the Implementation Guide or IG). The UnitedHealthcare Companion Guide identifies key data elements from the transaction set that we request you provide to us and response we will return. The recommendations made are to enable you to more effectively complete EDI transactions with UnitedHealthcare.

Updates to this companion guide will occur periodically and new documents will be posted on www.UnitedHealthcareOnline.com > News. These updates will also be available at http://www.uniprise.com/hipaa/companion_docs.html and distributed to all registered trading partners with reasonable notice, or a minimum of 30 days, prior to required implementation.

In addition,

- All trading partners will receive an email with a summary of the updates and a link to the new documents posted online.

- Trading partners can also sign up for email alerts on www.UnitedHealthcareOnline.com > News > Register to receive important news and updates including the Network Bulletin. Information will be included in these alerts anytime an updated 270/271 document is posted online.

1.3. REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange (004010X092A1) Eligibility Inquiry and Response (270/271) and to purchase copies of these documents, consult the Washington Publishing Company web site at www.wpc-edi.com

1.4. ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator and clearinghouse for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America.

2. GETTING STARTED

2.1. CONNECTIVITY WITH UNITEDHEALTHCARE

There are two methods to connect with UnitedHealthcare for submitting and receiving EDI transactions; direct or via a clearinghouse.

Clearinghouse Connections:

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss their ability to support the 270/271 004010X092A1 Health Care Eligibility Benefit Inquiry and Response transaction, as well as associated timeframe, costs, etc. Physicians and Healthcare professionals also have an opportunity to submit and receive a suite of EDI transactions via the Ingenix EDI Services (IEDIS) clearinghouse. For more information, please contact your IEDIS Account Manager. If you do not have an IEDIS Account Manager, please contact the IEDIS Sales Team at (800) 341-6141 option 3 for more information.

Direct Connection to UnitedHealthcare:

Direct connection to UnitedHealthcare for the purpose of 270/271 004010A1 Eligibility Benefit Inquiry and Response transaction submission will be available via Connectivity Director. This connection type will support batch and real-time submissions and responses.

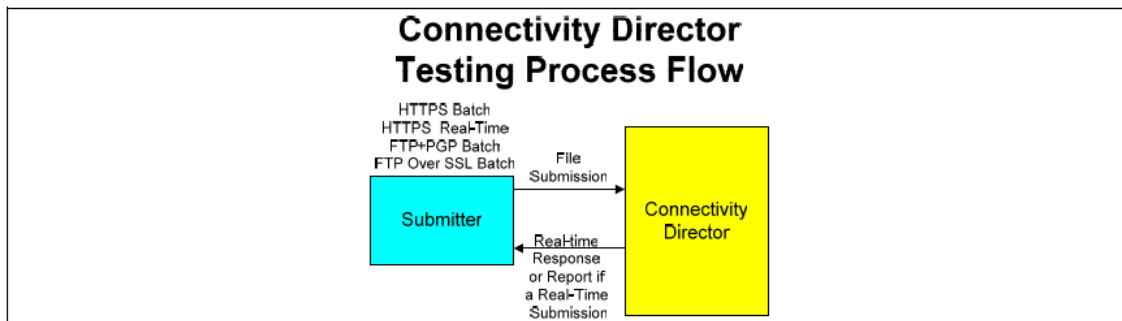
Register for Connectivity Director

Trading partners are able to get more information and register for Connectivity Director via this link www.unitedhealthcarecd.com.

2.2. CERTIFICATION AND TESTING OVERVIEW

All trading partners who wish to submit Eligibility Transactions to UnitedHealthcare via the ASC X12 270 (Version 004010X092A1) and receive corresponding EDI responses (271) must complete testing to ensure that their systems and connectivity are working correctly before any production transactions can be processed. Connectivity Director will assist in this process.

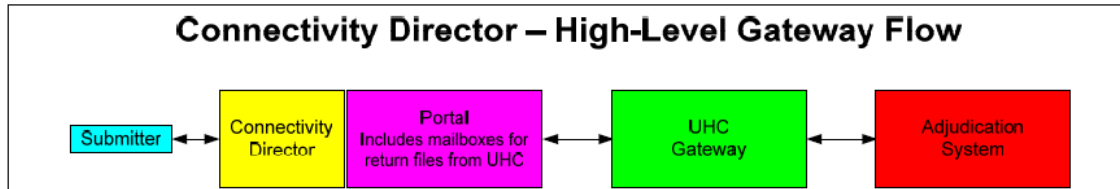
The following diagram shows the process flow for a testing scenario.



Trading partners are able to get more information and register on Connectivity Director via this link www.unitedhealthcarecd.com.

3. CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

3.1. PROCESS FLOWS



Batched Eligibility Benefit Inquiry and Response:

The response to a batch of Eligibility Inquiry transactions will consist of:

- 1) A batch containing one 997 Functional Acknowledgement transaction.
- 2) A second batch containing one 271 or 997 response transaction for each 270 submitted in the batch.

When a batch of eligibility transactions is received, the individual transactions within the batch are first checked for format compliance. A 997 Functional Acknowledgement transaction is then created indicating number of transactions that passed and failed the initial edits. A 997 Functional Acknowledgement transaction is only sent back when we receive a Batch. AK2 identifies the transaction set and AK5 identifies if the transaction set in AK2 accepted or rejected. AK9 indicates the number of transaction sets received and accepted.

Transactions that passed the format validation are then de-batched and processed individually. Each transaction is sent through another map to validate the individual eligibility transaction. Transactions that fail this edit will generate a 997 with an error message indicating that there was a map validation error.

Transactions that pass the validation edit, but fail further on in the processing (for example; ineligible member) will generate a 271 response including an AAA segment indicating the nature of the error.

Transactions that passed the validation edits and successfully process are sent to eligibility and benefits systems for final processing to generate a 271 response for each transaction.

All of the response transactions including those resulting from the initial edits (997s and 271) from each of the 270 requests are batched together and sent to the submitter.

Real-time Eligibility Benefit Inquiry and Response:

The response to a real-time eligibility transaction will consist of:

- 1) A real-time 997 transaction, if the submitted 270 failed format edits, OR
- 2) A real-time 271 response transaction indicating the eligibility benefits OR AAA segment indicating the nature of the error

Each transaction is first validated to ensure that the 270 complies with the IG. Transactions which fail this validation will generate a real-time 997 message back to the sender with an error message indicating that there was a map validation error. Transactions that pass the validation but failed to process (due to member eligibility, for example) will generate a real-time 271 response transaction including an AAA segment indicating the nature of the error. Transactions which pass initial validation are passed to the Eligibility and benefit systems.

A 271 response will be created using the information in our eligibility and benefits system.

Please note that this section contains UnitedHealthcare's approach to the 270/271 eligibility transactions. After careful review of the existing IG for the Version 004010X092A1 eligibility and associated response transactions we have compiled the UnitedHealthcare specific companion guide. We are not responsible for any changes and updates made to the Implementation Guide. Please refer to the IG as mentioned in the links in section 1.3 of this document.

3.2. TRANSMISSION ADMINISTRATIVE PROCEDURES

The Connectivity Director system can be used in either batch or real-time modes, either manually via the website (batch only) or programmatically via several different communication protocols.

3.3. COMMUNICATION PROTOCOL SPECIFICATIONS

Connectivity Director currently supports the following communications methods.

- HTTPS Batch and Real-Time
- FTP + PGP Batch
- FTP over SSL Batch

3.4. PASSWORDS

Submitter if not already set up needs to register online through the links provided in section 2.1 Register for an account (new user) and enter the required information for online application for Connectivity Director set up.

After your application has been approved, you will receive a username and password by email.

3.5. COSTS TO CONNECT

There is no cost imposed on the trading partners by UnitedHealthcare to set-up or use Connectivity Director.

3.6. SYSTEM AVAILABILITY & DOWNTIME

UnitedHealthcare's normal business hours for 270/271 EDI processing are as follows:

Monday through Friday: 7 am – 11 pm (Eastern)

Saturday: 7 am – 6 pm (Eastern)

Sunday: 7 am – 4 pm (Eastern)

Outside these windows, UnitedHealthcare eligibility systems may be down for general maintenance and upgrades. During these times, our ability to process incoming 270/271 EDI transactions may be impacted. The codes returned in the AAA segment of the 270

acknowledgement will instruct the trading partner if any action is required. These codes are as follows:

<i>Processing Impact</i>	<i>UnitedHealthcare System Response</i>	<i>Trading Partner Action Required</i>
EDI 270 cannot be processed	271 with AAA03 = 42 and AAA04 = R in loop 2000A	The system is not available at this time. Please try again later.
EDI 270 will be accepted and processed	See Response Transactions section 7.2 in this guide	Based on the response received

In addition, unplanned system outages may also occur occasionally and impact our ability to accept or immediately process incoming 270 transactions. We will send an email communication for scheduled and unplanned outages.

4. CONTACT INFORMATION

4.1. EDI CUSTOMER SERVICE

Most questions can be answered by referencing the materials posted at www.UnitedHealthcareOnline.com > News. Updates to companion guide will also be posted at: http://www.uniprise.com/hipaa/companion_docs.html If you have questions related to UnitedHealthcare's Eligibility & Benefits, please contact your clearinghouse vendor. For transactions submitted directly to UnitedHealthcare, please contact 877-842-3210. For any direct connectivity issues or questions, please contact UnitedHealthcare EDI Support at Unitedhelpdesk@ediconnect.com

5. CONTROL SEGMENTS / ENVELOPES

5.1. ISA -IEA

Transactions transmitted during a session or as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

5.2. GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope. The number of GS/GE functional groups that exist in the transmission.

5.3. ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE).

For real time transactions, this will always be '1'. A 270 file can only contain 270 transactions.

5.4. Control Segment Hierarchy:

ISA - Interchange Control Header segment

GS - Functional Group Header segment

ST - Transaction Set Header segment

First 270 Transaction

SE - Transaction Set Trailer segment

ST - Transaction Set Header segment

Second 270 Transaction

SE - Transaction Set Trailer segment

ST - Transaction Set Header segment

Third 270 Transaction

SE - Transaction Set Trailer segment
GE - Functional Group Trailer segment
IEA - Interchange Control Trailer segment

5.5. Control Segment Notes:

- The ISA segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be space filled.
- The first element separator (byte 4) in the ISA segment defines the element separator to be used through the entire interchange.
- The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange.
- ISA16 defines the component element separator used throughout the entire interchange.

5.6. FILE DELIMITERS

UnitedHealthcare requests that you use the following delimiters on your 270 file. If used as delimiters, these characters (* ~ :) must not be submitted within the data content of the transaction sets. Please contact UnitedHealthcare if there is a need to use a delimiter other than the following:

Data Element: The first element separator following the ISA will define what Data Element Delimiter is used throughout the entire transaction. **The recommended Data Element Delimiter is an asterisk (*).**

Segment: The last position in the ISA will define what Segment Element Delimiter is used throughout the entire transaction. **The recommended Segment Delimiter is a tilde (~).**

Component-Element: Element ISA16 will define what Component-Element Delimiter is used throughout the entire transaction. **The recommended Component-Element Delimiter is a colon (:).**

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1. 270 REQUEST

1. Eligibility requests for any explicit service type code (EB03) as well as a generic service type code "30" will generate a 271 response. The 271 response will be the same as if a generic service type code "30" (Health Benefit Plan Coverage) 270 request came in. Even though a 271 response will be created for any service code that does not mean that the service code requested will be in the eligibility response.
2. The search logic uses a combination of the following data elements: Member ID, Last Name, First Name and Patient Date of Birth (DOB). Values for each one of these data elements are not required. Cascading search logic will go through the criteria supplied and attempt to find a match. If a match is not found or multiple matches are found, a 271 response will be sent indicating to the user if possible what criteria needs to be supplied to find a match.

The following table describes the data received for each search scenario that will be supported.

SCENARIO	Patient/Member ID	Last Name	First Name	Patient DOB
1	X	X	X	X
2	X	X		X
3	X		X	X
4	X			X
5	X	X	X	
6		X	X	X

6.2. 271 RESPONSE

1. The following HIPAA service type codes (2110C/D EB03) may be reported in the 271 response:

EB03 value	Description
1	Medical Care
30	Health Benefit Plan Coverage

33	Chiropractic
35	Dental Care
47	Hospital
48	Hospital – Inpatient
50	Hospital – Outpatient
52	Hospital Emergency Medical (Emergency Room)
68	Well Baby Care
81	Routine Physical
86	Emergency Services (Urgent Care)
88	Pharmacy
91	Brand Name Prescription Drug
92	Generic Prescription Drug
96	Professional (Physician)
98	Primary Care Physician
98	Professional Physician Visit - Office
A4	Psychiatric (Mental Health)
AL	Vision (optometry)
A6	Psychotherapy
A7	Psychiatric - Inpatient
A8	Psychiatric - Outpatient
AE	Physical Medicine

2. An eligibility benefit (EB) data segment indicating active (1), inactive (6) or non-covered (I) in loop 2110C/D EB01 will be returned for supported HIPAA service type codes in the 271 response to.

Active Benefit Example:

EB*1**88 = active coverage for individual in-network pharmacy benefits

Inactive Benefit Example:

EB*6**35 = inactive dental coverage

DTP*349*D8*20080630 = coverage ended on of 6/30/2008

Non-covered Benefit Example:

EB*I**96 = Specialist is not covered:

3. When applicable an EB data segment in loop 2110C/D will be returned with benefit level co-payments, coinsurance and base deductible amounts. Remaining deductible will be returned if available.

Base deductible example for a benefit:

EB*C*IND*33***500***Y = individual has a \$500 base deductible for in-network chiropractic care

Remaining deductible example for a benefit:

EB*C*IND*33***29*183***Y = individual has a \$183 remaining deductible for in-network chiropractic care

4. When a benefit has multiple in-network co-payments, coinsurance, deductibles, limitations or cost containment measures a message segment will be sent distinguishing between multiple in-network benefits. The message segment will directly follow loop 2110C/D and EB data element that the message applies to.

Highest in-network benefit coinsurance example:

EB*A*IND*81***27**20***Y~ = individual has a 20% coinsurance for in-network routine physical

MSG* HIGHEST BENEFIT = highest benefit level for in-network benefits

5. The eligibility response will populate loop 2100C/D – EB03 valued with 30 - DTP01 with '307' to represent the health plan coverage start and end dates. When only one date is sent in the response the date represents the member's eligibility start date.

Health plan coverage example:

DTP*307*D8*20070501 = Member eligibility started on 05/01/2007

6. Insurance type code when available will be returned in EB04 data element in the health plan coverage (loop – 2100C/D), cost containment (loop 2110C/D) and out-of-pocket (loop – 2100C/D).

Insurance type code example:

EB*1**C1*Choice Plus = Member has active coverage under a commercial plan – Choice Plus

7. The remaining health plan (in loop 2110C/D EB03 = 30) deductible and out-of-pocket values will be returned in the 271 response.

Remaining deductible example:

EB*C*IND*30***29*266***Y = Individual In-network health plan remaining deductible is \$266

8. When UnitedHealthcare knows of additional payers and knows the name of the other payer, the other payer name will be sent in the 2110C/D loop with EB01 valued with 'R'. In the 2120C/D loop a NM1 data segment will be included to identify the other payer name.

Additional payer example:

EB*R**30~ = Additional payer exists

LS*2120~ = Loop identifier start

NM1*PR*2*MEDICARE~ = Non-person payer name is Medicare

LE*2120 = Loop identifier end

9. An EB data segment in loop 2110C/D will be included in the 271 response for any limitations that apply to a benefit.

Limitation dollar example:

EB*F*IND*33***23*500****Y = Individual in-network chiropractor benefits are limited to \$500 per calendar year

Limitation visit example:

EB*F*IND*33***25***VS*5**Y = Individual in-network chiropractor benefits are limited to 5 visits per contract (policy) year

Limitation visit example with Health Care Services Delivery (HSD) data segment:

EB*F*IND*96*****Y~ = Limitation for individual in-network Professional (Physician)

HSD*VS*5***34*6 = limitation period is 5 visits in 6 months

Limitation dollar example with HSD segment:

EB*F*IND*33***500****Y~ = \$500 limitation for individual in-network chiropractor benefits

HSD*****34*6 = Limitation period is 6 months

Additional covered dollar per occurrence/day limitation example:

EB*F*IND*48***20****Y~ = \$20 limitation for individual in-network hospital-inpatient.

MSG*Additional Covered per Occurrence = Additional covered dollars per occurrence/day which identifies the additional dollar allowance over the semi-private rate. Allow the semi-private room rate plus \$20.00.

10. An EB data segment in loop 2110C/D will be included in the 271 response for any cost containment measures that apply to a benefit. Cost containment is defined as a penalty that impacts a member's financial responsibility for member non-authorization.

Cost Containment example:

EB*J*IND*A7*C1*****Y*Y

MSG*Prior authorization is required otherwise member's financial responsibility will not be at the network level

11. An EB data segment in loop 2110C/D with the vendor's name will be included in the 271 response when a benefit is administered by another vendor.

Vendor name example:

EB*U**35~ = Contact following vendor for dental benefits

LS*2120~ = Loop identifier start

NM1*VN*2*ABC Dental~ = Non-Person vendor name is ABC Dental

LE*2120 = Loop identifier end

12. In loop 2110C/D a date or time or period (DTP) data segment will be included within the EB segment when the benefits' begin or end date is different than the health plans' begin or end date.

Benefit end date example:

EB*6**35~ = Dental coverage is in-active

DTP*349*D8*20080630 = Benefit coverage ends on 6/30/2008

13. If the patient is sent in the 270 2100D dependent loop, but UnitedHealthcare determines the patient is the subscriber, the 271 response will include the patient in the subscriber 2100C loop. If a TRN segment was submitted in the 270 2000D Loop, it will be returned in the 271 2000C Loop.
14. If the patient is sent in the 270 2100C subscriber loop, but UnitedHealthcare determines the patient is a dependent, the 271 response will include the patient in dependent 2100D loop. If a TRN segment was submitted in the 270 2000C Loop, it will be returned in the 271 2000D Loop.
15. Only the following HIPAA error codes will be used when a subscriber (2100C loop) is not found:
 - a. 58 – Invalid/Missing Date of Birth
 - b. 64 – Invalid/Missing Patient ID
 - c. 65 – Invalid/Missing Patient Name
 - d. 67 – Patient Not Found

- e. 71 – Patient Birth Date Does Not Match That for the Patient on the database
- f. 72 – Invalid/Missing Subscriber/Insured ID
- g. 73 – Invalid/Missing Subscriber/Insured Name
- h. 75 – Subscriber/Insured Not Found

Example:

AAA*Y**72*C = Valid request using an invalid/missing subscriber ID, change/add subscriber ID and resubmit.

16. Only the following HIPAA error codes will be used when a dependent (2100D loop) is not found:

- i. 58 – Invalid/Missing Date of Birth
- j. 64 – Invalid/Missing Patient ID
- k. 65 – Invalid/Missing Patient Name
- l. 67 – Patient Not Found
- m. 71 – Patient Birth Date Does Not Match That for the Patient on the database

Example:

AAA*Y**64*C= Valid request using an invalid/missing patient ID, change/add patient ID and resubmit.

7. TRANSACTION SPECIFIC INFORMATION

UnitedHealthcare has put together the following grid to assist you in designing and programming the information we would provide in 271 Response to your 270 Request. This Companion Guide is meant to illustrate the data provided by UnitedHealthcare for successful eligibility benefit inquiry and response transactions. The table contains a row for each segment that UnitedHealthcare has something additional, over and above, the information in the IG. That information can:

1. Limit the repeat of loops or segments
2. Limit the length of a simple data element
3. Specify a subset of the IG internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with UnitedHealthcare

All segments, data elements, and codes supported in the X12 IG are acceptable; however, all data may not be used in the processing of this transaction by UnitedHealthcare for a 270 request.

7.1. ELIGIBILITY BENEFIT REQUEST 270 (04010X092A1)

Data Elements

IG Page #	Loop ID	Reference	Name	HIPAA Codes	Notes/Comments
Eligibility Search Date Check -> DTP*307*D8*20050301~					
88 /130	2100C /D	DTP01	Date Time Qualifier		Used to specify type of date or time. Ex. 307 = Eligibility
		DTP02	Date Time Period Format Qualifier	D8	Used to qualify date time period format.
		DTP03	Date Time period		Used to specify date for eligibility search. Ex. 20080301 = CCYYMMDD
Payer Information -> NM1*PR*2*UNITEDHEALTHCARE****PI*87726~					
44	2100A	NM101	Entity Identifier Code	PR	Used to identify organizational entity. Ex. PR = Payer
45		NM102	Entity Type Qualifier		Used to indicate entity or individual person. Ex. 2 = Non-Person Entity
45		NM103	Name Last or Organization name		Used to specify subscribers last name. Ex. UNITEDHEALTHCARE
45		NM104	Name First		Used to specify subscribers first name.
45		NM105	Name Middle		Used to specify subscribers middle name.
45		NM106	Name Prefix		Used to specify subscribers name prefix.
45		NM107	Name Suffix		Used to specify subscribers name suffix.
46		NM108	Identification Code Qualifier		Used to qualify the identification number submitted. Ex. PI = Payor Identification

46		NM109	Identification Code		Used to specify primary source information identifier The changes will apply to commercial and government business for UnitedHealthcare. (Payer ID's – 87726 and 94265) Ex. 87726 Interpretation: Payer ID – 87726
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7.2. ELIGIBILITY BENEFIT RESPONSE 271 (004010X092A1)

Data Elements

IG Page #	Loop ID	Reference	Name	HIPAA Codes	Notes/Comments
HRA Balance Information -> EB*F*FAM***HEALTH REIMBUSMENT ACCOUNT*29*500*****Y~					
219 /296	2110C /D	EB01	Eligibility or Benefit Information	F	Used to specify that member has benefit level limitation.
221/298		EB02	Coverage Level Code	FAM	Health Reimbursement Account (HRA) balance applies to the family.
228/305		EB05	Plan Coverage Description		Used to specify that this member has a HRA plan. Ex. Health Reimbursement Account
228/205		EB06	Time Period Qualifier	29	Used to specify that the value in field EB07 is the remaining HRA balance.
229/305		EB07	Monetary Amount		Used to specify the HRA dollar amount remaining. Ex. 500
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network. Interpretation: Remaining family HRA balance is \$500
HRA Balance Message / Error Conditions -> EB*F*FAM***HEALTH REIMBUSMENT ACCOUNT*29*0*****Y~ MSG01* HRA FUNDS HAVE BEEN EXUASTED					
219 /296	2110C /D	EB01	Eligibility or Benefit Information	F	Used to specify that member has benefit level limitation.
221/298		EB02	Coverage Level Code	FAM	Health Reimbursement Account (HRA) balance applies to the family.

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228/305		EB05	Plan Coverage Description		Used to specify that this member has a HRA plan. Ex. Health Reimbursement Account
228/205		EB06	Time Period Qualifier	29	Used to specify that the value in field EB07 is the remaining HRA balance.
229/305		EB07	Monetary Amount		Used to specify the HRA dollar amount remaining. Ex. 0
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network. Interpretation: Remaining family HRA balance is \$0
321	2110C	MSG01	Free Form Message Text		A message segment is added to the 271 response when the HRA remaining balance being returned is zero. Ex. HRA FUNDS HAVE BEEN EXUASTED
HRA Balance Message / Error Conditions -> EB*F*FAM***HEALTH REIMBUSMENT ACCOUNT*29*****Y~ MSG01*HRA BALANCE IS UNAVAILBLE AT THIS TIME. FOR BALANCE INFORMATION PLEASE CALL THE TOLL FREE NUMBER LOCATED ON THE PATIENT'S CARD					
219 /296	2110C /D	EB01	Eligibility or Benefit Information	F	Used to specify that member has benefit level limitation.
221/298		EB02	Coverage Level Code	FAM	Health Reimbursement Account (HRA) balance applies to the family.
228/305		EB05	Plan Coverage Description		Used to specify that this member has a HRA plan. Ex. Health Reimbursement Account
228/205		EB06	Time Period Qualifier	29	Used to specify that the value in field EB07 is the remaining HRA balance.
229/305		EB07	Monetary Amount		Used to specify the HRA dollar amount remaining.
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network. Interpretation: Remaining family HRA balance is unavailable at this time
321	2110D	MSG01	Free Form Message Text		This message is returned when HRA balance information is not available due to technology issues. Ex. HRA BALANCE IS UNAVAILBLE AT THIS TIME. FOR BALANCE INFORMATION PLEASE CALL THE TOLL FREE NUMBER LOCATED ON THE PATIENT'S CARD.
Plan has benefit level limitation (Dollars) -> EB*F*IND*33***23*500*****Y~					
219/296	2110C/D	EB01	Limitation	F	Used to specify that member has benefit level limitation

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221/298		EB02	Coverage Level Code	IND	Used to specify limitation applies to an Individual.
221/298		EB03	Service Type Code		Used to specify limitation applies to service type. Ex. 33 = Chiropractic
229/305		EB07	Monetary Amount		Used to specify the monetary amount limitation for the member. Ex. 500 Interpretation: Individual in-network chiropractor benefits are limited to \$500 per calendar year
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network.
Plan has benefit level limitation (Visits) -> EB*F*IND*33***25***VS*5**Y~					
219/296	2110C/D	EB01	Limitation	F	Used to specify that member has benefit level limitation.
221/298		EB02	Coverage Level Code	IND	Used to specify limitation applies to an Individual.
221/298		EB03	Service Type Code		Used to specify limitation applies to service type. Ex.33 = Chiropractic
228/305		EB06	Time Period Qualifier		Used to qualify the time period category for the benefit. Ex.25 = Contract
229/306		EB09	Visits		Used to specify the type of units / counts for the benefit. Ex. VS = VISITS
230/306		EB10	Quantity		Used to specify the number of visits limitation for the member. Ex. 5 Interpretation: Individual in-network chiropractor benefits are limited to 5 visits per contract (policy) year
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network.
Plan has benefit level limitation (Visits) with Health Care Services Delivery (HSD) data segment -> EB*F*IND*96*****Y~ HSD*VS*5***34*6					
219/296	2110C/D	EB01	Limitation	F	Used to specify that member has benefit level limitation.
221/298		EB02	Coverage Level Code	IND	Used to specify limitation applies to Individual.

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221/298		EB03	Service Type Code		Used to specify limitation applies to service type. Ex 96 = Professional(Physician)
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network.
234/311		HSD01	Quantity Qualifier		Used to specify the visits for Professional (physician) limitation Ex. VS = VISITS
234/311		HSD02	Quantity		Used to specify the number of visits allowed for Professional (physician) limitation. Ex. 5
235/312		HSD05	Time period qualifier		Used to specify the time period allowed for Professional (physician) limitation. Ex. 34 = Month
235/312		HSD06	Number of periods		Used to specify length of period. Ex: 6 Interpretation: limitation is 5 visits in 6 months
Plan has benefit level limitation (Dollars) with Health Care Services Delivery (HSD) data segment -> EB*F*IND*33****500****Y~ HSD****34*6					
219/296	2110C/D	EB01	Limitation	F	Used to specify that member has benefit level limitation.
221/298		EB02	Coverage Level Code	IND	Used to specify limitation applies to an Individual.
221/298		EB03	Service Type Code		Used to specify limitation applies to service type. Ex.33 = chiropractic EB03 with visit limitation using Health Care Services Delivery (HSD) data segment
229/305		EB07	Monetary Amount		Used to specify the monetary amount limitation for the member. Ex. 500
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network.
235/312		HSD05	Time period qualifier		Used to specify the time period allowed for Professional (physician) limitation. Ex. 34 = Month

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235/312		HSD06	Number of periods		Used to specify length of period. Ex: 6 Interpretation: limitation is \$500 per 6 months
Plan has benefit level limitation - Additional covered dollar per occurrence/day -> EB*F*IND*48****20*****Y~ MSG01* ADDITIONAL COVERED PER OCCURENCE					
219/296	2110C/D	EB01	Limitation	F	Used to specify that member has benefit level limitation.
221/298		EB02	Coverage Level Code	IND	Used to specify limitation applies to an Individual.
221/298		EB03	Service Type Code		Used to specify limitation applies to Service type. Ex. 48 = Hospital Inpatient
229/305		EB07	Monetary Amount		Used to specify the monetary amount limitation for the member. Ex. 20
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network.
244/321		MSG01	Free Form Message Text		A message segment is added to the 271 response when the tier is Highest Benefit. Ex. MSG* ADDITIONAL COVERED PER OCCURENCE Interpretation: Additional covered dollars per occurrence/day which identifies the additional dollar allowance over the semi-private rate. Allow the semi-private room rate plus \$20.00
Plan has benefit level cost containment measures -> EB*J*IND*A7*C1*****Y*Y MSG* HIGHEST BENEFIT					
219/296	2110C/D	EB01	Cost Containment	J	Used to specify that member has benefit level cost containment.
221/298		EB02	Coverage Level Code	IND	Used to specify benefit applies to an Individual.
221/298		EB03	Service Type Code		Used to specify limitation applies to Service type. Ex. A7 = Psychiatric Inpatient

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226/303		EB04	Insurance Type Code		Used to specify Insurance Type code applies to member. Ex. C1 = Commercial
230/307		EB11	Authorization or certification Indicator	Y	Used to specify member needs authorization or certification per plan provisions.
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network.
244/321		MSG01	Free Form Message Text		A message segment is added to the 271 response when the tier is Highest Benefit. Ex. MSG*HIGHEST BENEFIT Interpretation: Prior authorization is required otherwise member's financial responsibility will not be at the network level
Highest in-network benefit coinsurance -> EB*A*IND*52***27**20****Y~ MSG*HIGHEST BENEFIT					
219/296	2110C/D	EB01	Co-Insurance	A	Used to specify that member benefit has co-insurance.
221/298		EB02	Coverage Level Code	IND	Used to specify co-insurance applies to an individual.
221/298		EB03	Service Type Code		Used to specify the service type code the co-insurance applies to. Ex. 52 = Hospital Emergency -Medical
228/305		EB06	Time Period Qualifier		Used to specify the time period category for the benefit. Ex.27 = Visit
229/306		EB08	Percent		Used to specify percent of co-insurance that applies to the member. Ex. 20%
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network
244/321		MSG01	Free Form Message Text		A message segment is added to the 271 response when the tier is Highest Benefit. Ex. MSG*HIGHEST BENEFIT Interpretation: Co-Insurance of 20% applies to member's financial responsibility at the network level

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Multiple service codes returned -> EB*A*IND*98***27**20****Y~ MSG*OFFICE VISIT ~ EB*A*IND*98***27**10****Y~ MSG*PRIMARY CARE PHYSICIAN					
219/296	2110C/D	EB01	Co-Insurance	A	Used to specify that member benefit has co-insurance.
221/298		EB02	Coverage Level Code	IND	Used to specify benefit coinsurance applies to Individual.
221/298		EB03	Service Type Code		Used to specify coinsurance applies to service type. Ex. 98 = professional physician visit office
228/305		EB06	Time Period Qualifier		Used to specify the time period for the benefit. Ex.27 = Visit
229/306		EB08	Percent		Used to specify percent of co-insurance that applies the member. Ex. 20%
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network.
244/321		MSG01	Free Form Message Text		A message segment is added to the 271 response when two "98" service type codes are returned. Ex. MSG*OFFICE VISIT Interpretation: Co-Insurance of 20% applies to member's financial responsibility at the network level when place of service is office visit
219/296	2110C/D	EB01	Co-Insurance	A	Used to specify that member benefit has co-insurance.
221/298		EB02	Coverage Level Code	IND	Used to specify benefit coinsurance applies to Individual.
221/298		EB03	Service Type Code		Used to specify coinsurance applies to service type. Ex. 98 = professional physician visit office
228/305		EB06	Time Period Qualifier		Used to specify the time period for the benefit. Ex.27 = Visit
229/306		EB08	Percent		Used to specify percent of co-insurance that applies the member. Ex. 10%
230/307		EB12	In Plan Network indicator	Y	Used to specify benefit is in-network.

244/321		MSG01	Free Form Message Text	<p>A message segment is added to the 271 response when two “98” service type codes are returned. Ex. MSG*PRIMARY CARE PHYSICIAN Interpretation: Co-Insurance of 10% applies to member's financial responsibility at the network level when place of service is primary care physician</p>
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8. APPENDECIES

8.1. FILE NAMING CONVENTIONS

Inbound Batch Eligibility Request to UnitedHealthcare

Z or N_270B_< Submitter ID (ISA06)>_< Interchange Control Number (ISA13)>.BTC.pgp

Example:

N_270B_ABC123456789_000000004.BTC.pgp

Outbound Responses from UnitedHealthcare

A.) 997 Functional Acknowledgement (Batch Only):

Z or N_270997_<batch ID>_<submitter ID >_<datetimestamp>.RES.pgp

Example:

Z_270997_000000004_ABC123456789_01102008142034. RES.pgp

B.) 271 (Batch Only): (May contain 997 transactions too)

N or Z_270271_< Interchange Control Number (ISA13)>_< submitter ID >_<datetimestamp>.RES.pgp

Example:

N_270271 _000000004_ABC123456789_01102008142034.RES.pgp

File Naming Notes:

1. The Date/Time format used in the file names is as follows: MMDDYYYYHHMMSS (Time is expressed in military format based on central time zone).
2. The batch number in the 270 eligibility request file name must be equal to ISA13 in the Interchange control header within the file.
3. 270997 file name will have the Interchange control header (ISA13) value received in the inbound file but the ISA13 in the 270997 file will have an internal generated number.

4. In 270271 file name will have the Interchange control header (ISA13) value received in the inbound file and the ISA13 in the 270271 file will also have the Interchange control header (ISA13) value received in the inbound file.
5. The submitter ID in the 270B eligibility file name must be equal to ISA06 in the Interchange Control Header within the file.
6. The submitter ID in the 270271 eligibility file name will be equal to ISA06 in the Interchange Control Header within the file.
7. The submitter ID in the 270997 eligibility file name will be equal to ISA06 in the Interchange Control Header within the file.
8. The name of the 997 Functional Acknowledgement file will include the Interchange control header (ISA13) value received in the inbound file.
9. All response files will be sent as either zipped or unzipped. The file will be sent back to the customer in the same way that it was sent to UnitedHealthcare. If the 270 request was sent zipped, B2B will send the response file zipped.
10. 'N' identifies the file as being unzipped and 'Z' identifies the file as being zipped. The extension '.BTC' is an abbreviation for batch.
11. If a batch is received with an invalid file name according to the specifications in the File Naming Conventions section 8.1 in this guide. The file will not be processed and submitter needs to call UnitedHealthcare follow-up.
12. The ISA13 should always be unique per file, per day (this is to ensure files are not overlaid when FTPd).

8.2. FREQUENTLY ASKED QUESTIONS

1. ***What is MN 62J?***

Minnesota regulations now require specific capabilities in the 270/271 transactions within Minnesota. These requirements are HIPAA-compliant and provide additional functionality to the eligibility inquiry.

2. ***Does this Companion Guide apply to only MN providers?***

While the legislation was passed by Minnesota, UnitedHealthcare has determined that it will be making these changes for all business, not just business in Minnesota.

3. *Does this Companion Guide apply to all UnitedHealthcare payers?*

No. The changes will apply to commercial and government business for UnitedHealthcare using payer ID 87726. This also applies to Medica payer ID 94265.

4. *Do the changes in the Companion Guide affect sending the 270 request transaction?*

Yes – The search logic uses a combination of the following data elements: Member ID, Last Name, First Name and Patient Date of Birth (DOB) as detailed in section 6.1.2 of this document.

5. *Do the changes in the Companion Guide affect the 271 response transaction?*

Yes. The trading partners will see more information in the 271 response and as described in section 7.2 of this document. This companion guide is used in conjunction with the MN Uniform Companion Guide for the 270/271 which is available at Minnesota Department of Health website:

<http://www.health.state.mn.us/asa/rules.html>

6. *How does UnitedHealthcare support, monitor, and communicate expected and unexpected connectivity outages?*

Our systems do have planned outages. For the most part, transactions will be queued during those outages. We have identified the planned maintenance windows in the UnitedHealthcare section 3.6 of this document. We will send an email communication for scheduled and unplanned outages.

7. *If a 270 is successfully transmitted to UnitedHealthcare, are there any situations that would result in no response being sent back?*

No. UnitedHealthcare will always send a response. Even if UnitedHealthcare's systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.