Minnesota Department of Health (MDH) Rule

Minnesota Uniform Companion Guide (MUCG) Version 14.0 for the Implementation of the ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

Effective April 4, 2024

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1.Introduction and Overview

This is version 14.0 of the Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271). It was adopted into rule pursuant to Minnesota Statutes, section 62J.61.

1.1. How to obtain a copy of this document

This document is available at no charge on the Minnesota Uniform Companion Guides webpage (https://www.health.state.mn.us/facilities/ehealth/auc/guides/index.html).

1.2. Applicable statutes and requirements

Minnesota Statutes, section 62J.536 (https://www.revisor.mn.gov/statutes/cite/62J.536) requires health care providers (https://www.revisor.mn.gov/statutes/cite/62J.03), group purchasers (payers) (https://www.revisor.mn.gov/statutes/cite/62J.03), and health care clearinghouses (https://www.revisor.mn.gov/statutes/cite/62J.51) to exchange certain health care business (administrative) transactions electronically. These exchanges must comply with the specifications of the appropriate single uniform "companion guide" adopted into rule by the Commissioner of Health in consultation with a large, voluntary external stakeholder advisory organization, the Minnesota Administrative Uniformity Committee (AUC) (https://www.health.state.mn.us/facilities/ehealth/auc/index.html). The state's companion guide rules are known as "Minnesota Uniform Companion Guides (MUCG)" and are promulgated and adopted pursuant to Minnesota Statutes, section 62J.61 (https://www.revisor.mn.gov/statutes/cite/62J.61). Other state statutes also reference MS §62J.536.

Note: Compliance with a companion guide rule adopted pursuant to MS §62J.536 does not mean that a health care claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

Additional information regarding Minnesota's requirements for the standard, electronic exchange of health care administrative transactions, including relevant rules, examples of entities that are subject to MS §62J.536, Frequently Asked Questions (FAQs) and other information, is available on the MDH Administrative Simplification Act webpage (https://www.health.state.mn.us/facilities/ehealth/asa/index.html).

1.3. Further description and use of this document

This document:

- Describes the proposed data content and other transaction specific information to be used with the ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response

(270/271) hereinafter referred to as 005010X279A1, by entities subject to Minnesota Statutes, section 62J.536.

- Supplements, but does not otherwise modify the 005010X279A1 in a manner that will make its implementation by users to be out of compliance.
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N X12 and NCPDP implementation specifications).
- Was prepared by the Minnesota Department of Health (MDH) (https://www.health.state.mn.us) with the assistance of the Minnesota Administrative Uniformity Committee (AUC) (https://www.health.state.mn.us/facilities/ehealth/auc/index.html).

1.4. Reference for this document

The reference for this document [(the X12 "Implementation Guide- Type 3 (TR3)" technical report] is the ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12. Format © 2008, ASC X12. All Rights Reserved), hereinafter described below as 005010X279A1. A copy of the full 005010X279A1 can be obtained from the X12 store (http://store.x12.org/store/). Learn more about licensing X12's work at Licensing Program | X12 (https://x12.org/products/licensing-program).

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1.5. Best practices for the implementation of electronic health care transactions

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. While use of the best practices is not required per statute, their use is strongly encouraged to aid in meeting the state's health care administrative data exchange requirements, and to provide the greatest benefits of health care administrative simplification. Please visit the AUC best practices webpage (https://www.health.state.mn.us/facilities/ehealth/auc/bestpractices/index.html) for more information about best practices for implementing electronic health care administrative transactions in Minnesota.

1.6. Contact for further information

Minnesota Department of Health
Division of Health Policy
Center for Health Information Policy and Transformation
Email: health.ASAguides@state.mn.us

2.How to use this document

2.1. Classification and display of Minnesota-specific requirements

This document provides transaction specific information to be used in conjunction with the 005010X279A1 and other applicable information and specifications noted in section 1.2 above. Information needed to comply with Minnesota Statutes, section 62J.536 is provided in narrative and outline forms regarding search scenarios, rejected transactions, and reporting of patient financial responsibility, and in tables 3.2 and 4.2 as described below.

Tables 3.2 and 4.2 contain a row for each segment for which there is additional information over and above the information in the 005010X279A1. The tables show the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

Given that the 005010X279A1 is a "paired" transaction, Table 3.2 presents information for the 005010X279A1 Health Care Eligibility Benefit Inquiry (270) transaction, and Table 4.2 presents information for the 005010X279A1 Health Care Eligibility Benefit Response (271) transaction.

2.2. Search scenarios and rejected transactions (Error Messages)

Search Scenarios

Information Sources must use the search scenarios described in Table 1, Section 2.3 below when responding to 005010X279A1 Health Care Eligibility Benefit Inquiry (270) transactions sent by Information Receivers. The goal of these search scenarios is to increase the number of matches found by an Information Source. By maximizing the number of automated matches, both Information Receivers and Information Sources will experience fewer follow-up phone calls, which will reduce administrative costs. The six unique search scenarios are based on the four data elements that make up the Required Primary Search Option from the 005010X279A1 Health Care Eligibility Benefit Inquiry transaction: Subscriber ID, Last Name, First Name and Date of Birth (DOB). Information Receivers should submit every available search scenario data element in each 005010X279A1 Health Care Eligibility Benefit Inquiry (270) transaction.

The Information Source must utilize the search scenario that matches the data elements submitted in the 005010X279A1 Health Care Eligibility Benefit Inquiry (270) transaction. For example, if the Information Source receives Subscriber ID, Last Name, First Name and DOB, it must use Scenario 1. If the Information Source receives only the Last Name, First Name and DOB of the Subscriber, then it must use Scenario 6.

The scenarios are designed so that an Information Source continues to look for the Subscriber/Dependent even if some of the data elements submitted do not match the Information Source's system. The scenarios are not intended to require Information Receivers

to continually resend the 005010X279A1 Health Care Eligibility Benefit Inquiry (270) transaction to fit the different scenarios.

Note regarding e-prescribing use cases: The search scenario requirements above do not apply to "e-prescribing", which is defined in Minnesota Statutes, section 62J.497, Subd. 1(e) (https://www.revisor.mn.gov/statutes/cite/62J.497) as: "the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information."

2.3. Rejected transaction reporting (AAA Segment Usage)

When an Information Source is unable to find the subscriber/dependent using one of the six Search Scenarios below, the Search Scenarios define a standard way to report that the Information Source is unable to respond with eligibility information for the subscriber/dependent. The goal is to use a unique error code for a given error condition.

Refer to the 005010X279A1 for further information about rejecting a transaction for reasons other than subscriber/dependent not found.

Table 1-- Search scenarios

Scenario	SUBSCRIBER 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

Scenario #1: (Subscriber ID, Last Name, First Name, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits, Go to J.

B. Filter with DOB

- Filter result with unique hit, Positive response
- Filter result with multiple hits, Go to C.
- Filter result with no hits, Go to H.

C. Filter with Last Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits, Go to D.
- Filter result with no hits, Go to F.

D. Filter with first 3 letters of First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits, Go to E.
- Filter result with no hits
  - If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  - If Dependent ("Invalid Missing Patient Name"–65)

E. Filter with full First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits
  - If Subscriber ("Duplicate Subscriber/Insured ID"–76)
  - If Dependent ("Duplicate Patient ID"–68)
- Filter result with no hits
  - If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  - If Dependent ("Invalid Missing Patient Name"–65)

F. Start over with B results and filter with first 3 letters of First Name

- Filter result with unique hit, Positive response

- Filter result with multiple hits, Go to G.
- Filter result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name”–65)

G. Filter with full First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name”–65)
- Filter result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name” –65

H. Start over with A results and filter with Last Name and first 3 letters of First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits, Go to I.
- Filter result with no hits, Go to J.

I. Filter with full First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits (“Patient DOB does not match that for the patient on the database”–71)
- Filter result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73 and “Patient DOB does not match that for the patient on the database”–71)
  - If Dependent (“Invalid Missing Patient Name”–65 and “Patient DOB does not match that for the patient on the database”–71)

J. Start over and search with Last Name, first 3 letters First Name, and DOB.

- Search result with unique hit, Positive response
- Search result with multiple hits, Go to K.
- Search result with no hits
  - If reached from Step A

- If Subscriber ("Invalid Missing Subscriber/Insured ID"–72 and "Invalid Missing Subscriber/Insured Name"–73 and "Patient DOB does not match that for the patient on the database"–71)
- If Dependent ("Invalid Missing Patient ID"–64 and "Invalid Missing Patient Name"–65 and "Patient DOB does not match that for the patient on the database"–71)

- Else
  - If Subscriber ("Invalid Missing Subscriber/Insured Name"–73 and "Patient DOB does not match that for the patient on the database"–71)
  - If Dependent ("Invalid Missing Patient Name"–65 and "Patient DOB does not match that for the patient on the database"–71)

K. Filter with full First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits
  - If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
  - If Dependent ("Invalid Missing Patient ID"–64 add Loop whenever term pt ID is used)
- Filter result with no hits
  - If reached from Step A and then J
    - If Subscriber ("Invalid Missing Subscriber/Insured ID"–72 and "Invalid Missing Subscriber/Insured Name"–73)
    - If Dependent ("Invalid Missing Patient ID"–64 add Loop and "Invalid Missing Patient Name"–65)
  - Else
    - If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
    - If Dependent ("Invalid Missing Patient Name"–65)

Scenario #2: (Subscriber ID, Last Name, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits
  - If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
  - If Dependent ("Invalid Missing Patient ID"–64)

B. Filter with DOB

- Filter result with unique hit, Positive response
- Filter result with multiple hits, Go to C.
- Filter result with no hits ("Patient DOB does not match that for the patient on the database"–71)

C. Filter with Last Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits
  - If Subscriber ("Invalid Missing Subscriber/Insured Name"-73)
  - If Dependent ("Invalid Missing Patient Name"–65)
- Filter result with no hits
  - If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  - If Dependent ("Invalid Missing Patient Name"–65)

Scenario #3: (Subscriber ID, First Name, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits
  - If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
  - If Dependent ("Invalid Missing Patient ID"–64 – add Loop)

B. Filter with DOB

- Filter result with unique hit, Positive response
- Filter result with multiple hits, Go to C.
- Filter result with no hits ("Patient DOB does not match that for the patient on the database"–71)

C. Filter with first 3 letters of First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits, Go to D.
- Filter result with no hits
  - If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)

- If Dependent (“Invalid Missing Patient Name”–65)

D. Filter with full First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name”–65)
- Filter result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name”–65)

Scenario #4: (Subscriber ID, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
  - If Dependent (“Invalid Missing Patient ID”–64 – add Loop)

B. Filter with DOB

- Filter result with unique hit, Positive response
- Filter result with multiple hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name”–65)
- Filter result with no hits (“Patient DOB does not match that for the patient on the database”–71)

Scenario #5: (Subscriber ID, Last Name, First Name)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)

- If Dependent (“Invalid Missing Patient ID”–64 – add Loop)

B. Filter with Last Name

- Filter result with unique hit, Go to C.
- Filter result with multiple hits, Go to C.
- Filter result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name”–65)

C. Filter with first 3 letters of First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits, Go to D.
- Filter result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name”–65)

D. Filter with full First Name

- Filter result with unique hit, Positive response
- Filter result with multiple hits (“Invalid/Missing DOB”–58)
- Filter result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name”–65)

Scenario #6: (Last Name, First Name, DOB)

A. Search with Last Name, first 3 letters First Name, and DOB.

- Search result with unique hit, Positive response
- Search result with multiple hits, Go to B.
- Search result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73 and “Patient DOB does not match that for the patient on the database”–71)
  - If Dependent (“Invalid Missing Patient Name”–65 and “Patient DOB does not match that for the patient on the database”–71)

B. Filter with full First Name

- Filter result with unique hit, Positive response

- Filter result with multiple hits
  - If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
  - If Dependent (“Invalid Missing Patient ID”–64 add Loop)
- Filter result with no hits
  - If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
  - If Dependent (“Invalid Missing Patient Name”–65)

2.4. Reporting patient financial responsibility and related benefit information

2.4.1 Instructions

Information Sources must return any known related benefit information and patient financial responsibility (PFR) if the Subscriber/Dependent is found (positive response), consistent with applicable CORE operating rules, especially Phase II CORE 260, sections 3.2, 4.1.3, and 6.1. PFR includes the following:

- Co-Payment
- Co-Insurance
- Deductible (base and remaining).

Information sources must also return as applicable:

- Out of pocket
- Cost containment.

The only exceptions to the requirement to return PFR are for the service type codes listed in Phase II CORE 260, section 4.1.3. and those listed as “discretionary” in Phase II CORE 260, section 6.1. Related benefit information includes limitations, exclusions, etc.

When reporting related benefit information or PFR for a component level service type code, do not also report the information at the “generic” service type code level.

For example: If reporting different PFR amounts for Durable Medical Equipment Purchase (service type code 12) and Durable Medical Equipment Rental (service type code 18), do not report any PFR amount for service type code DM – Durable Medical Equipment.

3.Transaction Specific Information (270)

3.1. Introduction to table

This table summarizes transaction specific information to be used in conjunction with the 005010X279A1 and any other applicable information and specifications noted in sections 1.2

through 2.4.1 above. Given that the 005010X279A1 is a “paired” transaction, this table is for the 005010X279A1 (270).

Note: Specific procedure/diagnosis code capability is not required and may not be supported by Information Sources.

3.2 005010X279A1 (270) transaction table

Loop	Segment	Data Element (if applicable)	Value Definition and notes
	BHT Beginning of Hierarchical Transaction	BHT02 Hierarchical Structure Code	13
LOOP ID 2100C SUBSCRIBER NAME	DTP Subscriber Date	N/A	Information Sources must support a benefit coverage date 12 months in the past, or length of time equal to their timely filing claim filing window if greater than 12 months. The requirement to support a benefit coverage date 12 months in the past does not apply to use cases with “e-prescribing”, as defined in Minn. Statute § 62J.497, Sec. 3, Subd, 1(d).
LOOP ID 2100D DEPENDENT NAME	DTP Dependent Date	N/A	Information Sources must support a benefit coverage date 12 months in the past, or a length of time equal to their timely filing window if greater than 12 months. The requirement to support a benefit coverage date 12 months in the past does not apply to use cases with “e-prescribing”, as defined in Minn. Stat. § 62J.497, Sec. 3, Subd. 1(d).

4.Transaction Specific Information (271)

4.1. Introduction to table

This table provides transaction specific information to be used in conjunction with the 005010X279A1 and any other applicable information and specifications noted in sections 1.2

through 3.2 above. Given that the 005010X279A1 is a “paired” transaction, this table is for the 005010X279A1 (271).

Note: Specific procedure/diagnosis code capability is not required and may not be supported by Information Sources.

4.2 005010X279A1 (271) transaction table

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
LOOP 2100B INFORMATION RECEIVER	NM1 Information Receiver Name	NM101 Entity Identifier Code	Information Source will return the data submitted in the 270 element
LOOP 2100B INFORMATION RECEIVER	NM1 Information Receiver Name	NM102 Entity Type Qualifier	Information Source will return the data submitted in the 270 element
LOOP 2100B INFORMATION RECEIVER	NM1 Information Receiver Name	NM 103 Name Last or Organization Name	Information Source will return the data submitted in the 270 element
LOOP 2100B INFORMATION RECEIVER	NM1 Information Receiver Name	NM104 Name First	Information Source will return the data submitted in the 270 element
LOOP 2100B INFORMATION RECEIVER	NM1 Information Receiver Name	NM105 Name Middle	Information Source will return the data submitted in the 270 element
LOOP 2100B INFORMATION RECEIVER	NM1 Information Receiver Name	NM107 Name Suffix	Information Source will return the data submitted in the 270 element
LOOP 2100B INFORMATION RECEIVER	NM1 Information Receiver Name	NM108 Identification Code Qualifier	Information Source will return the data submitted in the 270 element
LOOP 2100B INFORMATION RECEIVER	NM1 Information Receiver Name	NM109 Identification Code	Information Source will return the data submitted in the 270 element
LOOP 2100C SUBSCRIBER NAME	AAA Subscriber Request Validation	N/A	Refer to Section 2.3, Rejected Transaction Reporting, for more information.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
LOOP 2100C SUBSCRIBER NAME	DTP Subscriber Date	DTP01 Date/Time Qualifier	For only the “e-prescribing” use case, as defined in Minnesota Statutes, section 62J.497, either the code 291 or 307 may be returned.
LOOP 2100D DEPENDENT NAME	AAA Dependent Request Validation	N/A	Refer to Section 2.3, Rejected Transactions Reporting, for more information
LOOP 2100D DEPENDENT NAME	DTP Dependent Date	DTP01 Date/Time Qualifier	For only the “e-prescribing” use case, as defined in Minnesota Statutes, section 62J.497, either the code 291 or 307 may be returned