



January 23rd, 2019

2:00 pm – 4:00 pm

Teleconference/WebEx ONLY - ([Participant Instructions](#))

AUC Eligibility TAG

AGENDA

1. Meeting to Order

2. Welcome & Introductions – Please e-mail your attendance to Theresa.noponen@centracare.com

3. Anti-trust Statement – <http://www.health.state.mn.us/auc/pdfs/antitrust.pdf>

4. Approve Previous Meeting Minutes

5. Service Type Codes Presentation by MDH consultant, Doreen Espinoza

Presentation PowerPoint was sent out, any comments?

6. Continued exception from 270-271 exchange requirements for entities not subject to HIPAA

A unanimous approval for the exception, which this group did recommend for another year. However, (and noted on the ballot) *the TAG also recommended strongly that the AUC engage with the exempted payers and others during the coming year to help find a solution for more standard, automated exchanges of eligibility information between the parties.*

Per the notes from our last meeting we asked a few different questions for follow up:

- Approve with the caveat that work be done throughout the next year to identify data elements, usage of 270/271? Work with X12, CMS and other national organizations
- Federal HIPAA identified exempt entities are not required to use the 270/271, typically these are TPL, MVA, and WC payors, should we continue to allow this exemption?
- Why do we continue to allow this exemption?
- Should we ask these exempted entities to provide reasons for not being able to use 270/271?
- Have they done any research, development to become compliant?

7. Other Business

8. Meeting Summary & Next Steps

9. Next Meeting – Teleconference/WebEx ONLY February 27th, 2019 (2-4pm)

2019 Calendar, please mark your calendars accordingly.

Wednesday, January 23, 2019 (2-4pm)
Wednesday, February 27, 2019 (2-4pm)
Wednesday, March 27, 2019 (2-4pm)
Wednesday, April 24, 2019 (2-4pm)
Wednesday, May 22, 2019 (2-4pm)
Wednesday, June 26, 2019 (2-4pm)

Wednesday, July 24, 2019 (2-4pm)
Wednesday, August 28, 2019 (2-4pm)
Wednesday, September 25, 2019 (2-4pm)
Wednesday, October 23, 2019 (2-4pm)
Wednesday, November 27, 2019 (2-4pm)
Wednesday, December 18, 2019 (2-4pm)



November 28, 2018

2:00 pm – 4:00 pm

Teleconference/WebEx ONLY - ([Participant Instructions](#))

AUC Eligibility TAG

AGENDA

1. Meeting to Order

2. Welcome & Introductions – Please e-mail your attendance to Theresa.noponen@centracare.com

Andy Andersen	BJ Venhuizen
Clark Fenske	Dave Haugen
Doreen Espinoza	Doug Curtis
Jacki Rathke	Jake Varilek
Loni Wegman	Mary Winter
Nancy Senato	Patrice Lindgren
Quinn Thomas	Susan Lee
Theresa Noponen	Tim Lopez
Rigzin Dolma	

3. Anti-trust Statement – <http://www.health.state.mn.us/auc/pdfs/antitrust.pdf>

4. Approve Previous Meeting Minutes

5. Service Type Codes Presentation by MDH consultant, Doreen Espinoza

Presentation PowerPoint as a separate document. This presentation was recorded and will hopefully be available on the AUC website in the near future.

6. Continued exception from 270-271 exchange requirements for entities not subject to HIPAA

Federal HIPAA identified exempt entities are not required to use the 270/271, typically these are TPL, MVA, and WC payors, should we continue to allow this exemption?

In order to approve, can we receive answers to questions?

- Why do we continue to allow this exemption?
- Should we ask these exempted entities to provide reasons for not being able to use 270/271?
- Have they done any research, development to become compliant?
- Approve with the caveat that work be done throughout the next year to identify data elements, usage of 270/271? Work with X12, CMS and other national organizations

7. Other Business

8. Meeting Summary & Next Steps

9. Next Meeting – Teleconference/WebEx ONLY December 26th (2-4pm) – Do we want to keep on the calendar or look to January as our next meeting? Cancel – Please remove from your calendars.

Tentative 2019 Calendar, please mark your calendars accordingly.

Wednesday, January 23, 2019 (2-4pm)

Wednesday, February 27, 2019 (2-4pm)

Wednesday, March 27, 2019 (2-4pm)

Wednesday, April 24, 2019 (2-4pm)

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What's with the new Codes

By Doreen Espinoza

Level Setting

Simple Facts about Codes

What are the codes

Many of the Health Care Service Type Codes have, in the past, been considered both Health Benefit Plan Coverage Types and service types. To reduce confusion, Health Benefit Plan Coverage Type codes (Codes that begin with F) have been added to the Health Care Service Type Code external code set.

To request eligibility or benefits for all Health Benefit Plan Coverage Types associated to the patient on the 270, the submitter should send a Health Benefit Plan Coverage Request for Eligibility or General Benefit Request for Eligibility.

More About the codes

The current codes can be found at:

<http://www.x12.org/codes/health-care-service-type-codes/>

New Codes can be requested by using the Maintenance Request Form

Maintenance Request Form

It is recommended that individuals pursuing a new code or changes to a code message first contact their industry representative within the Code Maintenance Group or another member by email to discuss their request prior to submitting the form below.

Code Maintenance Group Member Listing

By doing so, this may facilitate their request by allowing someone familiar with the approval process to discuss an alternate solution (if appropriate) for their need, or enabling that member to obtain additional background information which could help with the request.

Requestors are not required to contact a member prior to submitting their request, but they would be strongly encouraged to do so. This process would allow the Code Maintenance Group to more fully understand and discuss requests and have more time at the meeting to do so.

Use the form below to request additions or revisions to the code lists.

For all requests: Name, Phone, Company, Email, Request Type and List Name are required.

Name	<input type="text"/>	Phone	<input type="text"/>
Company	<input type="text"/>	Email	<input type="text"/>
Brief description of request		<input type="text"/>	

Request Type	<input type="radio"/> Revision to existing code	List Name	<input type="radio"/> Claim Adjustment Reason Code
	<input type="radio"/> New code		<input type="radio"/> Health Care Claim Status
			<input type="radio"/> Health Care Claim Status Category
			<input type="radio"/> Health Care Services Review Decision Reason
			<input type="radio"/> Service Type

External Code List TR2 - Code list 958

- Used in both the 270/271 Eligibility/Benefit Inquiry and Response as well as the 278 Health Care Services Request for Review and Response
- Updated during the X12 Trimester Meetings: January/Feb –June and Sept/Oct
- Effective Dates

Codes Meeting	Meeting Month	Publication Date	Effective Date Choice 1	Choice 2	Choice 3
Winter	Jan/Feb	1-Mar	1-Mar	1-Jul	1-Nov
Summer	May/Jun	1-Jul	1-Jul	1-Nov	1-Mar
Fall	Sep/Oct	1-Nov	1-Nov	1-Mar	1-Jul

Example of the Types of Codes

Service Type Code	Description
1	Medical Care
4	Diagnostic X-Ray
5	Diagnostic Lab
33	Chiropractic
35	Dental Care
47	Hospitalization
86	Emergency Services
88	Retail/Independent Pharmacy
AL	Optometry
BY	Physician Visit-Sick
BZ	Physician Visit-Well
MH	Mental Health
UC	Urgent Care

Plan Coverage Type Code	Description
F1	Medical Coverage
F2	Social Work Coverage
F3	Dental Coverage
F4	Hearing Coverage
F5	Prescription Drug Coverage
F6	Vision Coverage
F7	Orthodontia Coverage
F8	Mental Health Coverage

Where are they Used

Request

- Eligibility Request 2110C Subscriber/2110 D Dependent EQ Segment

A request is not allowed to request a Service type code more than once in a single patient 270 request.

Response

- Eligibility Response 2110C Subscriber or 2110D Dependent Eligibility: Benefit Information
- 2105C Subscriber 2105 Dependent: Edibility/Benefits Information Grouping

Coverage and benefit details for a given STC must not be duplicated within a 271 response.

Payers and Providers

An information source must support all Health Care Service Type Codes and return all applicable financial and non-financial base amounts, regardless of the information receiver's provider taxonomy or specialty code if the benefit or service is billable or payable to a provider, or, the member has financial responsibility as part of their coverage or benefit plan.

This includes base deductible, co-insurance amounts, co-payment amounts, total allowed visits, total allowed sessions, and any other benefit related detail that does not disclose any patient usage-related information. Eligibility.

Ask Once

If an information source receives a **Health Benefit Plan Coverage Request for Eligibility** along **with another Health Care Service Type Code** in 2110C Subscriber or 2110D Dependent Eligibility or Benefit Inquiry EQ01 on the 270, it is recommended that the information source return an Implementation Acknowledgment for Health Care Insurance (999) transaction with the value "I12" – Implementation Pattern Match Failure in IK403 – Implementation Data Element Syntax Error Code.

General Inquiry using Service Type Codes

- eligibility status (i.e., active or not active in the plan)
- plan coverage date(s)
- maximum benefits (policy limits)
- exclusions
- in-network/out-of-network benefits
- C.O.B information
- deductible
- co-pays

Complex Inquiry using Service Type Codes

- eligibility status (i.e., active or not active in the plan)
- service type coverage date(s)
- service type coverage maximum amount(s) allowed
- deductible amount(s)
- remaining deductible amount(s)
- co-insurance amount(s)
- co-pay amount(s)
- coverage limitation percentage
- patient responsibility amount(s)
- non-covered amount(s)

Required Number of Service Type codes

An information source must respond to the first 10 Health Care Service Type Code received in the 270 2110C Subscriber or 2110D Dependent Eligibility or Benefit Inquiry EQ, and may support more than 10 Health Care Service Type Codes at their discretion.

EQ can be repeated 99 times

Simple Request

EQ – Segment Name

EQ01 Composite Element

EQ01-01: Service Type Code

EQ01-02: Descriptor

EQ*30*FAM~ [Where 30 = Health Benefit Plan Coverage]

Complex Request

EQ*42:43:AB~

42= Home Health Care

43 = Home Health Prescriptions

AB= Rehabilitation

Plan Coverage

Plan Coverage Type codes and benefit or service codes may not always reflect the payer's Plan Coverage Types and their benefit packages; therefore, the information receiver should not assume that because a benefit is not linked to an obvious Plan Coverage Type, that the benefit is not offered/covered. Rather, it may fall within or a part of a different Plan Coverage Type offering.

Plan Coverage Type Codes are allowed to be used by Payers not Providers.

F1 Medical Coverage

This code will be used by the payer on the 271 response to show coverage type. This code cannot be submitted with the 270 Inquiry

Example: Plan Coverage Type Code Response

If Mental Health benefit Health Care **Service Type Code** is **requested** but mental health benefits are covered under a Medical Plan Coverage Type offered by the payer, then the **response** for that Plan Coverage Type would contain the **Medical Plan Coverage Type code and the Mental Health benefit Health Care Service Type Code** using the 2110C Subscriber or 2110D Dependent Eligibility or Benefit Information repeating data element function in EB03-01.

If Mental health benefits are covered under a **Mental Health Plan Coverage Type** offered by the payer, then the **response** for that benefit should contain the **Mental Health Plan Coverage Type code and the Mental Health benefit Health Care Service Type Code** using the 2110C Subscriber or 2110D Dependent Eligibility or Benefit Information repeating data element function in EB03-01.

Mental Health Inquiry and Response

Request Service Type

EQ*MH~ [Where Service Type Code **MH = Mental Health**]

Response Plan Coverage

EB*1**F8~ [Where 1=Active and **F8=Mental Health Coverage**]

Mental Health Inquiry and Response

Request Service Type

EQ*A6~ [Where Service Type Code **A6 = Psychotherapy**]

Response Plan Coverage

EB*1*A6*F8~ [Where **1=Active** and **F8=Mental Health Coverage**]

Service Type Codes Apply to More than one Coverage type

For instance:

Screening X-ray Health Care Service Type Code may be returned one time, but may apply to multiple Plan Coverage Types, such as Medical Coverage and Dental Coverage.

Service Type Code Component Grouping

Service Type Code Component Grouping		47 - Hospitalization	
1 - Medical Care	1 - Medical Care 2 - Surgical 3 - Consultation 42 - Home Health Care 45 - Hospice 54 - Long Term Care 69 - Maternity 76 - Dialysis 83 - Infertility AG - Skilled Nursing Care BT - Gynecological BU - Obstetrical BY - Physician Visit - Sick BZ - Physician Visit - Well		47 - Hospitalization 88 - Retail/Independent Pharmacy 90 - Mail Order Pharmacy 91 - Brand Name Prescription Drug 92 - Generic Prescription Drug GF - Generic Prescription Drug - Formulary GN - Generic Prescription Drug - Non-Formulary