



Wednesday, December 18, 2019

2:00 pm – 4:00 pm

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

AUC Eligibility TAG

Agenda

1. **Call Meeting to Order**
2. **Welcome & Introductions** – Please e-mail your attendance to Tim.Lopez@bluecrossmn.com
3. **Anti-trust Statement** – <http://www.health.state.mn.us/auc/pdfs/antitrust.pdf>
4. **Approve Previous Meeting Minutes**
5. **Review MN AUC Operations updates**
 - a) General news/update
 - b) Chair/Co-Chair(s) search update? (Looking for a Payer to step up next. Any interest in Chairing or Co-Chairing for AUC Operations send to Bob or Dave)
6. **Annual maintenance of the MN companion guide**
 - a) Review MN companion guide while considering the following questions/concerns:
 - Is it serving the intended purpose?
 - Is everything correct and up to date?
 - Are there improvements we should consider?
 - Anything we can streamline and simplify?
 - Items may have seemed relevant and helpful several years ago, but may no longer be as helpful or relevant as it once was?
 - Any opportunities where adding to the 270-271 guide is a good idea?
 - Are there best practices that are important enough, have enough general applicability, and are likely to not change for some time, that they should be included in the guide (i.e., they should become part of a rule with the force of law, rather than a voluntary best practice)?
7. **Email Vote results for Reporting primacy information Best Practice**
 - a) 6 Approve and 4 abstain
 - Did UCare send in a vote?
 - DHS abstained as they do not have the information to return but is not against it.
 - Next steps? Do we have quorum?
8. **Discussion BP Reporting Two Digit Medicaid Program Code**
 - a) Review DRAFT Reporting Medicaid Program Code and Vote to approve publication
 - Removed 2-digit references which will now allow for any length and no longer a need for updating in the future should it change again

9. High Eligibility Volumes beginning of the month

- a) Is there a way to reduce those volumes?
 - Working ahead has been suggested as a possible solution. For the payors, can your system accurately return eligibility for future dates? The assumption is no, but we know there are some payors who can do this. What are the limitations?
- b) Does this cause issues for anyone else? What is the impact?
- c) Anything MN AUC can/should do to help?

10. Topics for upcoming meetings

- a) Education/Training Topics:
 - Using 6P vs 1L for group/policy
 - Payer feedback of common 270 provider request errors that can be avoided through some sort of education/tips.
- b) DRAFT BP – Cheat Sheet/Quick Reference Glossary – BJ has DRAFT prepared
- c) DRAFT BP - Correcting Membership information when a unique member is found (ID, First, Last, DOB)
- d) DRAFT BP - Requiring Accumulations for Calendar/Plan Year Deductible/Out of Pocket/Limitations
- e) DRAFT BP - Benefit response Disclaimer
- f) DRAFT BP - Returning Authorization Indicator EB11
- g) Update BP template to Reference the HIPAA Implementation Guide and the AUC Companion Guide

11. Other Business

12. Meeting Summary & Next Steps

13. Next Meeting – Teleconference/WebEx ONLY January 22, 2020 (2-4pm)

2020 Schedule, please mark your calendars accordingly:

- Wednesday, January 22, 2020 (2-4pm)
- Wednesday, February 26, 2020 (2-4pm)
- Wednesday, March 25, 2020 (2-4pm)
- Wednesday, April 22, 2020 (2-4pm)
- Wednesday, May 27, 2020 (2-4pm)
- Wednesday, June 24, 2020 (2-4pm)
- Wednesday, July 22, 2020 (2-4pm)
- Wednesday, August 26, 2020 (2-4pm)
- Wednesday, September 23, 2020 (2-4pm)
- Wednesday, October 28, 2020 (2-4pm)
- Wednesday, November 25, 2020 (2-4pm)
- Wednesday, December 23, 2020 (2-4pm)

14. Adjourn Meeting



Wednesday, October 23, 2019

2:00 pm – 4:00 pm

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

AUC Eligibility TAG

Meeting Minutes

1. Call Meeting to Order

2. Welcome & Introductions – Please e-mail your attendance to Tim.Lopez@bluecrossmn.com

- Susan.Lee@allina.com
- Fausto.Iglesias@hennepin.us
- JRathke@umphysicians.umn.edu
- clark.fenske@state.mn.us
- mary.winter@primewest.org
- adito1@ucare.org
- tim.lopez@bluecrossmn.com
- bob.b.johnson@state.mn.us

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

4. Approve Previous Meeting Minutes – Meeting Minutes Approved

5. Review MN AUC Operations updates

- Any update on the email Vote results for the following BP's? All 3 best practices were approved by AUC Operations and will be posted to the AUC website within the week.
 - Other or Additional Payor Information
 - Multiple Service Types
 - Reporting Funding Type
- Changes occurring with Chairs and Co-Chairs. Looking for a Payer to step up next. Announcement forthcoming. Any interest in Chairing or Co-Chairing for AUC Operations send to Bob or Dave.

6. Email Vote results for Reporting primacy information Best Practice

- 3 Approve and 4 abstain
 - Does not seem enough for passage
 - Next steps?
- Susie received 1 more vote for approve
- BCBS will send approve
- Hennepin Health will send vote to Approve.
- UCare will review and send in a Vote
- Why did people Abstain? DHS abstained as they do not have the information to return but is not against it. No others on the phone.
- Bob will talk to Dave about what is needed for a quorum.

7. Discussion BP Reporting Two Digit Medicaid Program Code

- Discuss removing the “2 digit” wording piece on the best practice as I am sure its possible it could change even further in the future and maybe end up being more than the current 4 digits?
- Provider wanted 4-digit code MA02 and the Payer was only sending MA.
- Payer wondering if they could return 4 digit “Product Code”.
- DHS sends both the 4-digit Product code and the 2-digit program code. DHS advised EB01 = MC is being used to convey that information. Clark DHS will do further research and advise next meeting.
- Requirements also exist for 835.
- Options
 - Incorporate the 4 digit code into the existing Best Practice
 - Create a new Best Practice
 - OR the 4 digit code is not important enough for a Best Practice
- Think there used to be a Two digit Program code TAG? Bob will ask Dave for contact info. Jackie UMP will send Tim some old email info on the topic.

8. Annual maintenance of the MN companion guide

- Is it serving the intended purpose?
- Is everything correct and up-to-date?
- Are there improvements we should consider?
- Anything we can streamline and simplify?
- Items may have seemed relevant and helpful several years ago, but may no longer be as helpful or relevant as it once was
- Any opportunities where adding to the 270-271 guide is a good idea?
- Are there best practices that are important enough, have enough general applicability, and are likely to not change for some time, that they should be included in the guide (i.e., they should become part of a rule with the force of law, rather than a voluntary best practice)?
- No comments about any changes or suggestions currently. Tim will send email out and ask to everyone review for the next meeting. Plan is to go over section by section super high-level next meeting.
- Should not be an issue if we don't get companion guide review completed before end of year.

9. Topics for upcoming meetings

- Education/Training Topics:
 - Using 6P vs 1L for group/policy
 - Payer feedback of common 270 provider request errors that can be avoided through some sort of education/tips.
- DRAFT BP – Cheat Sheet/Quick Reference Glossary – BJ has DRAFT prepared
- DRAFT BP - Correcting Membership information when a unique member is found (ID, First, Last, DOB)
- DRAFT BP - Requiring Accumulations for Calendar/Plan Year Deductible/Out of Pocket/Limitations
- DRAFT BP - Benefit response Disclaimer
- DRAFT BP - Returning Authorization Indicator EB11
- Update BP template to Reference the HIPAA Implementation Guide and the AUC Companion Guide

10. Other Business

11. Meeting Summary & Next Steps

- Concern with Thanksgiving holiday day after our meeting. Possible will cancel November meeting. Tim and Susan will discuss with Bob. Decision was made to cancel.
- Next meeting we will revisit the 2 vs 4 digit code Best Practice and review the Companion Guide more thoroughly.

12. Next Meeting – Teleconference/WebEx ONLY November 27, 2019 (2-4pm)

2019 Calendar, please mark your calendars accordingly.

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

Wednesday, December 18, 2019 (2-4pm)

13. Adjourn Meeting



Minnesota Department of Health Rule

Title:	Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271). Version 12.0.
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to/interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536, and others
Description of this document:	<p>This document was adopted into rule on March 26, 2018.</p> <p>[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.]</p> <p>This document:</p> <ul style="list-style-type: none"> • 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 covered under Minnesota Statutes, section 62J.536; • Is intended to 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 and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	<p>This is version 12.0 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 announced as an adopted rule in the Minnesota State Register, Volume 42, Number 39, March 26, 2018 pursuant to Minnesota Statutes, sections 62J.536 and 62J.61.</p> <p>This document is available at no charge on the homepage for Minnesota's health care administrative simplification initiative, www.health.state.mn.us/asa.</p>

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1 Overview

1.1 Statutory basis for this proposed rule

Minnesota Statutes, section 62J.536 requires the Commissioner of Health to adopt rules for the standard, electronic exchange of specified health care administrative transactions. The state's rules are promulgated and adopted pursuant to Minnesota Statutes, section 62J.61.

1.2 Applicability of state statute and related rules

The following entities must exchange certain transactions electronically pursuant to Minnesota Statutes, section 62J.536: all group purchasers (payers) and health care clearinghouses licensed or doing business in Minnesota; and health care providers providing services for a fee in Minnesota and who are otherwise eligible for reimbursement under the state's Medical Assistance program.

The only exceptions to the statutory requirements are as follows:

- The requirements do NOT apply to the exchange of covered transactions with Medicare and other payers for Medicare products; and
- See section 1.2.1 "Exceptions to Applicability" below regarding a year to year exception for only non-HIPAA covered entities and only for the eligibility inquiry and response transaction.

[Minnesota Statutes, section 62J.03, Subd. 6](#) defines "group purchaser" as follows:

"Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

[Minnesota Statutes, section 62J.03, Subd. 8](#) defines "provider or health care provider" as follows:

"Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical

assistance except that those services are characterized as experimental, cosmetic, or voluntary.

[Minnesota Statutes, section 62J.536, Subd. 3](#) defines "health care provider" to also include licensed nursing homes, licensed boarding care homes, and licensed home care providers.

[Minnesota Statutes, section 62J.51, Subd. 11a](#) defines "health care clearinghouse" as follows:

"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

- 1) *processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;*
- 2) *receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;*
- 3) *acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section [62J.536](#);*
- 4) *acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section [62J.536](#); and*
- 5) *other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.*

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions."

Entities performing transactions electronically pursuant to Minnesota Statutes, section 62J.536 via direct data entry system (i.e., Internet-based interactive applications) must also comply with the data content requirements established in this document.

1.2.1 Exceptions to applicability

[Minnesota Statutes, section 62J.536, subd. 4](#) authorizes the Commissioner of Health to exempt group purchasers not covered by HIPAA (group purchasers not covered under United States Code, title 42, sections 1320d to 1320d-8) from one or more of the requirements to exchange information electronically as required by Minnesota Statutes, section 62J.536 if the Commissioner determines that:

- i. a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or*
- ii. another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.*

If group purchasers are exempt from one or more of the requirements, providers shall also be exempt from exchanging those transactions with the group purchaser.

The Commissioner has determined that criterion (i) above has been met for the eligibility

inquiry and response electronic transaction described under Code of Federal Regulations, title 45, part 162, subpart L, and that group purchasers not covered by HIPAA, including workers' compensation, auto, and property and casualty insurance carriers, are not required to comply with the state's rules for the eligibility inquiry and response transaction. This exception pertains only to those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (the *ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)*, hereinafter *005010X279A1*). This exception shall be reviewed on an annual basis; the status of the exception can be found at the [MS §62J.536 Implementation and Compliance webpage, http://www.health.state.mn.us/asa/implement.html](http://www.health.state.mn.us/asa/implement.html).

While the exception above is in effect, health care providers are also exempt from the rules for transactions with group purchasers who have been exempted. This exception is only for the rules for the eligibility inquiry and response electronic transaction with group purchasers not subject to HIPAA.

1.3 About the Minnesota Department of Health (MDH)

MDH is responsible for protecting, maintaining and improving the health of Minnesotans. The department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of health care providers. For more information, go to: <http://www.health.state.mn.us>.

1.3.1 Contact for further information on this document

Minnesota Department of Health
Division of Health Policy
Center for Health Care Purchasing Improvement
P.O. Box 64882
St. Paul, Minnesota 55164-0882
Phone: (651) 201-3570
Fax: (651) 201-3830
Email: health.ASAguides@state.mn.us

1.4 About the Minnesota Administrative Uniformity Committee

The Administrative Uniformity Committee (AUC) is a broad-based, voluntary organization representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The mission of the AUC is to develop agreement among Minnesota payers and providers on standardized health care administrative processes when implementation of the processes will reduce administrative costs. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. For more information, go to the [AUC website, http://www.health.state.mn.us/auc/index.html](http://www.health.state.mn.us/auc/index.html).

1.5 Minnesota 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. The best practices are not required to be used as part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

Please visit the AUC website at <http://www.health.state.mn.us/auc/index.html> for more information about best practices for implementing electronic health care transactions in Minnesota.

1.6 Document Changes

The content of this document is subject to change. The version, release and effective dates of the document are included in the document, as well as a description of the process for future updates or changes.

1.6.1 Process for updating this document

The process for updating this document is available from MDH's [Health Care Administrative Simplification webpage](http://www.health.state.mn.us/asa/index.html) at: <http://www.health.state.mn.us/asa/index.html>. The process includes: submitting and collecting change requests; reviewing and evaluating the requests; proposing changes; and adopting and publishing a new version of the document.

1.6.2 Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions
5.0	November 12, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions
7.0	September 23, 2013	Proposed revisions to v6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. Version 8.0 supersedes all previous versions
9.0	November 11, 2014	Proposed changes to version 8.0
10.0	March 9, 2015	Adopted into rule March 9, 2015. Version 10.0 incorporates changes proposed in v9.0 and additional changes. Version 10.0 supersedes all previous versions
11.0	January 2, 2018	Proposed changes to version 10.0 for public comment
12.0	March 26, 2018	Adopted into rule March 26, 2018. Version 12.0 incorporates changes proposed in v11.0 and additional changes. Version 12.0 supersedes all previous versions.

2 Purpose of this document and its relationship with other applicable regulations

2.1 Reference for this document

The reference for this document 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 ASC X12 at the [X12 store](http://store.x12.org/store/) (<http://store.x12.org/store/>).

2.1.1 Permission to use copyrighted information

[Placeholder: Express permission to use ASC X12 copyrighted materials within this document has been granted.]

2.2 Purpose and relationship

This document:

- Serves as transaction specific information to the 005010X279A1;
- 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 (ASC X12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the 005010X279A1 in a manner that will make its implementation by users to be out of compliance; and
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities covered by Minnesota Statutes, section 62J.536. In particular, the information in this document must be appropriately incorporated by reference and/or displayed in companion guides of covered entities to meet requirements of CFR 45 § 162.1203 for companion guide compliance with “Phase I CORE 152: Eligibility and Benefit Real Time Companion Guide Rule, version 1.1.0, March 2011, and CORE v5010 Master Companion Guide Template. (Incorporated by reference in § 162.920).”

Please note:

Using this Companion guide does not mean that a claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

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3 How to use this document

3.1 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 2.0 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 4.2 and 5.2 as described below.

- Tables 4.2 and 5.2 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 4.2 presents information for the *005010X279A1* Health Care Eligibility Benefit Inquiry (270) transaction, and Table 5.2 presents information for the *005010X279A1* Health Care Eligibility Benefit Response (271) transaction.

See also section 2.2 regarding the incorporation of the information in this document in any companion guides provided by or on behalf of entities covered by Minnesota Statutes, section 62J.536.

3.2 Search scenarios and rejected transactions (Error Messages)

3.2.1 Search scenarios

Information Sources must use the search scenarios described in Table 1, Section 3.2.3 - 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 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 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.”

3.2.2 Rejected transaction reporting (AAA Segment Usage)

When an Information Source is unable to find the subscriber/dependent using one of the six Search Scenarios, 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.

3.2.3 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Duplicate Subscriber/Insured ID”–76)
 - b) If Dependent (“Duplicate Patient ID”–68)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) If Dependent (“Invalid Missing Patient Name”–65)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73 and “Patient DOB does not match that for the patient on the database”–71)
 - b) 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
 - a) If reached from Step A
 - 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)
 - b. 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)
 - b) Else
 - a. If Subscriber (“Invalid Missing Subscriber/Insured Name”–73 and “Patient DOB does not match that for the patient on the database”–71)
 - b. 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) If Dependent (“Invalid Missing Patient ID”–64 add Loop whenever term pt ID is used)
- Filter result with no hits

- c) If reached from Step A and then J
 - 1) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72 and “Invalid Missing Subscriber/Insured Name”–73)
 - 2) If Dependent (“Invalid Missing Patient ID”–64 add Loop and “Invalid Missing Patient Name”–65)
- d) Else
 - 1) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - 2) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) If Dependent (“Invalid Missing Patient Name”–65)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) If Dependent (“Invalid Missing Patient Name”–65)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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

- a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
- b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73 and “Patient DOB does not match that for the patient on the database”–71)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) If Dependent (“Invalid Missing Patient ID”–64 add Loop)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) If Dependent (“Invalid Missing Patient Name”–65)

3.3 Reporting patient financial responsibility and related benefit information

3.3.1 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.

4 Transaction Specific Information (270)

4.1 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 2.0 through 3.3.1 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.

4.2 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).

5 Transaction Specific Information (271)

5.1 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 2.0 through 3.3.1 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.

5.2 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 3.2.2 , Rejected Transaction Reporting, for more information. For only the “e- prescribing” use case, as defined in

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
LOOP 2100C SUBSCRIBER NAME	DTP Subscriber Date	DTP01 Date/Time Qualifier	Minnesota Statutes, section 62J.497, either the code 291 or 307 may be returned.
LOOP 2100D DEPENDENT NAME	AAA Dependent Request Validation		Refer to Section 3.2.2 , 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



Minnesota Department of Health Rule

Title:	Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271). Version 12.0.
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to/interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536, and others
Description of this document:	<p>This document was adopted into rule on March 26, 2018.</p> <p>[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.]</p> <p>This document:</p> <ul style="list-style-type: none"> • 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 covered under Minnesota Statutes, section 62J.536; • Is intended to 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 and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	<p>This is version 12.0 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 announced as an adopted rule in the Minnesota State Register, Volume 42, Number 39, March 26, 2018 pursuant to Minnesota Statutes, sections 62J.536 and 62J.61.</p> <p>This document is available at no charge on the homepage for Minnesota's health care administrative simplification initiative, www.health.state.mn.us/asa.</p>

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1 Overview

1.1 Statutory basis for this proposed rule

Minnesota Statutes, section 62J.536 requires the Commissioner of Health to adopt rules for the standard, electronic exchange of specified health care administrative transactions. The state's rules are promulgated and adopted pursuant to Minnesota Statutes, section 62J.61.

1.2 Applicability of state statute and related rules

The following entities must exchange certain transactions electronically pursuant to Minnesota Statutes, section 62J.536: all group purchasers (payers) and health care clearinghouses licensed or doing business in Minnesota; and health care providers providing services for a fee in Minnesota and who are otherwise eligible for reimbursement under the state's Medical Assistance program.

The only exceptions to the statutory requirements are as follows:

- The requirements do NOT apply to the exchange of covered transactions with Medicare and other payers for Medicare products; and
- See section 1.2.1 "Exceptions to Applicability" below regarding a year to year exception for only non-HIPAA covered entities and only for the eligibility inquiry and response transaction.

[Minnesota Statutes, section 62J.03, Subd. 6](#) defines "group purchaser" as follows:

"Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

[Minnesota Statutes, section 62J.03, Subd. 8](#) defines "provider or health care provider" as follows:

"Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical

assistance except that those services are characterized as experimental, cosmetic, or voluntary.

[Minnesota Statutes, section 62J.536, Subd. 3](#) defines "health care provider" to also include licensed nursing homes, licensed boarding care homes, and licensed home care providers.

[Minnesota Statutes, section 62J.51, Subd. 11a](#) defines "health care clearinghouse" as follows:

"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

- 1) *processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;*
- 2) *receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;*
- 3) *acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section [62J.536](#);*
- 4) *acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section [62J.536](#) and*
- 5) *other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.*

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions."

Entities performing transactions electronically pursuant to Minnesota Statutes, section 62J.536 via direct data entry system (i.e., Internet-based interactive applications) must also comply with the data content requirements established in this document.

1.2.1 Exceptions to applicability

[Minnesota Statutes, section 62J.536, subd. 4](#) authorizes the Commissioner of Health to exempt group purchasers not covered by HIPAA (group purchasers not covered under United States Code, title 42, sections 1320d to 1320d-8) from one or more of the requirements to exchange information electronically as required by Minnesota Statutes, section 62J.536 if the Commissioner determines that:

- i. a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or*
- ii. another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.*

If group purchasers are exempt from one or more of the requirements, providers shall also be exempt from exchanging those transactions with the group purchaser.

The Commissioner has determined that criterion (i) above has been met for the eligibility

inquiry and response electronic transaction described under Code of Federal Regulations, title 45, part 162, subpart L, and that group purchasers not covered by HIPAA, including workers' compensation, auto, and property and casualty insurance carriers, are not required to comply with the state's rules for the eligibility inquiry and response transaction. This exception pertains only to those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (the *ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)*, hereinafter *005010X279A1*). This exception shall be reviewed on an annual basis; the status of the exception can be found at the [MS §62J 536 Implementation and Compliance webpage, http://www.health.state.mn.us/asa/implement.html](http://www.health.state.mn.us/asa/implement.html).

While the exception above is in effect, health care providers are also exempt from the rules for transactions with group purchasers who have been exempted. This exception is only for the rules for the eligibility inquiry and response electronic transaction with group purchasers not subject to HIPAA.

1.3 About the Minnesota Department of Health (MDH)

MDH is responsible for protecting, maintaining and improving the health of Minnesotans. The department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of health care providers. For more information, go to: <http://www.health.state.mn.us>.

1.3.1 Contact for further information on this document

Minnesota Department of Health
Division of Health Policy
Center for Health Care Purchasing Improvement
P.O. Box 64882
St. Paul, Minnesota 55164-0882
Phone: (651) 201-3570
Fax: (651) 201-3830
Email: health.ASAguides@state.mn.us

1.4 About the Minnesota Administrative Uniformity Committee

The Administrative Uniformity Committee (AUC) is a broad-based, voluntary organization representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The mission of the AUC is to develop agreement among Minnesota payers and providers on standardized health care administrative processes when implementation of the processes will reduce administrative costs. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. For more information, go to the [AUC website, http://www.health.state.mn.us/auc/index.html](http://www.health.state.mn.us/auc/index.html).

1.5 Minnesota 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. The best practices are not required to be used as part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

Please visit the AUC website at <http://www.health.state.mn.us/auc/index.html> for more information about best practices for implementing electronic health care transactions in Minnesota.

1.6 Document Changes

The content of this document is subject to change. The version, release and effective dates of the document are included in the document, as well as a description of the process for future updates or changes.

1.6.1 Process for updating this document

The process for updating this document is available from MDH's [Health Care Administrative Simplification webpage](http://www.health.state.mn.us/asa/index.html) at:

<http://www.health.state.mn.us/asa/index.html>. The process includes: submitting and collecting change requests; reviewing and evaluating the requests; proposing changes; and adopting and publishing a new version of the document.

1.6.2 Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions
5.0	November 12, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions
7.0	September 23, 2013	Proposed revisions to v6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. Version 8.0 supersedes all previous versions
9.0	November 11, 2014	Proposed changes to version 8.0
10.0	March 9, 2015	Adopted into rule March 9, 2015. Version 10.0 incorporates changes proposed in v9.0 and additional changes. Version 10.0 supersedes all previous versions
11.0	January 2, 2018	Proposed changes to version 10.0 for public comment
12.0	March 26, 2018	Adopted into rule March 26, 2018. Version 12.0 incorporates changes proposed in v11.0 and additional changes. Version 12.0 supersedes all previous versions.

2 Purpose of this document and its relationship with other applicable regulations

2.1 Reference for this document

The reference for this document 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 ASC X12 at the [X12 store](http://store.x12.org/store/) (<http://store.x12.org/store/>).

2.1.1 Permission to use copyrighted information

[Placeholder: Express permission to use ASC X12 copyrighted materials within this document has been granted.]

2.2 Purpose and relationship

This document:

- Serves as transaction specific information to the 005010X279A1;
- 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 (ASC X12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the 005010X279A1 in a manner that will make its implementation by users to be out of compliance; and
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities covered by Minnesota Statutes, section 62J.536. In particular, the information in this document must be appropriately incorporated by reference and/or displayed in companion guides of covered entities to meet requirements of CFR 45 § 162.1203 for companion guide compliance with “Phase I CORE 152: Eligibility and Benefit Real Time Companion Guide Rule, version 1.1.0, March 2011, and CORE v5010 Master Companion Guide Template. (Incorporated by reference in § 162.920).”

Please note:

Using this Companion guide does not mean that a claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

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3 How to use this document

3.1 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 2.0 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 4.2 and 5.2 as described below.

- Tables 4.2 and 5.2 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 4.2 presents information for the 005010X279A1 Health Care Eligibility Benefit Inquiry (270) transaction, and Table 5.2 presents information for the 005010X279A1 Health Care Eligibility Benefit Response (271) transaction.

See also section 2.2 regarding the incorporation of the information in this document in any companion guides provided by or on behalf of entities covered by Minnesota Statutes, section 62J.536.

3.2 Search scenarios and rejected transactions (Error Messages)

3.2.1 Search scenarios

Information Sources must use the search scenarios described in Table 1, Section 3.2.3 - 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 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 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.”

3.2.2 Rejected transaction reporting (AAA Segment Usage)

When an Information Source is unable to find the subscriber/dependent using one of the six Search Scenarios, 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.

3.2.3 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Duplicate Subscriber/Insured ID”–76)
 - b) If Dependent (“Duplicate Patient ID”–68)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) If Dependent (“Invalid Missing Patient Name”–65)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73 and “Patient DOB does not match that for the patient on the database”–71)
 - b) 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
 - a) If reached from Step A
 - 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)
 - b. 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)
 - b) Else
 - a. If Subscriber (“Invalid Missing Subscriber/Insured Name”–73 and “Patient DOB does not match that for the patient on the database”–71)
 - b. 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) If Dependent (“Invalid Missing Patient ID”–64 add Loop whenever term pt ID is used)
- Filter result with no hits

- c) If reached from Step A and then J
 - 1) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72 and “Invalid Missing Subscriber/Insured Name”–73)
 - 2) If Dependent (“Invalid Missing Patient ID”–64 add Loop and “Invalid Missing Patient Name”–65)
- d) Else
 - 1) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - 2) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) If Dependent (“Invalid Missing Patient Name”–65)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) If Dependent (“Invalid Missing Patient Name”–65)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) 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

- a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
- b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73 and “Patient DOB does not match that for the patient on the database”–71)
 - b) 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
 - a) If Subscriber (“Invalid Missing Subscriber/Insured ID”–72)
 - b) If Dependent (“Invalid Missing Patient ID”–64 add Loop)
- Filter result with no hits
 - a) If Subscriber (“Invalid Missing Subscriber/Insured Name”–73)
 - b) If Dependent (“Invalid Missing Patient Name”–65)

3.3 Reporting patient financial responsibility and related benefit information

3.3.1 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.

3.4 [Reporting Termination Date for Inactive Coverage \(PDF\)](#)

3.5 [Service Type Inquiry/Response \(PDF\)](#)

3.6 [Reporting Other or Additional Payor Information \(PDF\)](#)

4 Transaction Specific Information (270)

4.1 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 2.0 through 3.3.1 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.

4.2 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).
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5 Transaction Specific Information (271)

5.1 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 2.0 through 3.3.1 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.

5.2 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 3.2.2 , Rejected Transaction Reporting, for more information. For only the “e- prescribing” use case, as defined in

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
LOOP 2100C SUBSCRIBER NAME	DTP Subscriber Date	DTP01 Date/Time Qualifier	Minnesota Statutes, section 62J.497, either the code 291 or 307 may be returned.
LOOP 2100D DEPENDENT NAME	AAA Dependent Request Validation		Refer to Section 3.2.2 , 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



This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.**

1. Title of best practice:

Reporting Medicaid Program Code

2. Who does the best practice apply to:

Information Sources and Information Receivers

3. Narrative description as to what is being addressed by this best practice:

Provide the DHS major program code for Prepaid Medical Assistance Plans (PMAP). Currently Hospitals access the DHS eligibility system which validates eligibility by program and date spans for all inpatient claims to meet the Medicare requirements for Disproportionate Share reimbursement.

Providers (hospitals and physicians) need the PMAP eligibility response to include the DHS program code which identifies the specific DHS program. Data analysis and extraction is necessary to allow validation for Medicare Disproportionate Share (DSH), Minnesota Department of Health (MDH) Medical Education Research Committee reporting (MERC), DHS (Department of Human Services) Disproportionate Share (DSH) reporting, and MDH Hospital Annual Report (HAR/HCCIS).

4. The loops, segments and elements, etc. that the best practice applies to:

271 – Loop 2110C, REF segment

5. Describe how to do the best practice:

It is recommended when Information Sources send a 271 response for a member identified as a PMAP member the Medicaid program code should be returned.

6. Examples to illustrate best practice:

HL*3*2*22*0
NM1*IL*1*LAST*FIRST*M***MI*99999999
REF*6P*9999
REF*NQ*99999999
N3*123 ABC STREET

N4*ANYCITY*MN*55999
DMG*D8*YYYYMMDD*F
DTP*346*D8*20100201
EB*1**30**PMAP PLAN/PRODUCT NAME*****Y
REF*M7*PMAP AAAA
(Note: can use REF03 if a description is needed)

7. AUC approval date:

MM/DD/YYYY

8. Last reviewed date:

12/18/19