HIPAA Transactions:
270/271, 278/278 and 276/277

Michigan Department of Community Health
May 1, 2003
Agenda

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- Glossary
- Transaction Overview
- 270/271 Eligibility Benefit Inquiry and Response
- 278/278 Authorization/Certification Request and Response
- 276/277 Healthcare Claim Status Request and Response
- Questions
Glossary
# Glossary

<table>
<thead>
<tr>
<th>HIPAA/Industry Term</th>
<th>Medicaid Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim</td>
<td>Invoice</td>
<td>A single paper form, or a collection of services by a single billing provider for a single patient, billed at one time.</td>
</tr>
<tr>
<td>Service Line</td>
<td>Claim Line</td>
<td>A single service generally associated with a procedure code.</td>
</tr>
<tr>
<td>Replacement</td>
<td>Adjustment</td>
<td>A billing provider’s request to change a previously submitted claim.</td>
</tr>
<tr>
<td>Void/Cancel</td>
<td>Adjustment</td>
<td>A billing provider’s request to void a previously submitted claim.</td>
</tr>
<tr>
<td>Health Care Claim Adjustment</td>
<td></td>
<td>The difference between the billing provider’s usual charges and the paid amount. The reason for the difference is described through the use of Health Care Claim Adjustment Reason Codes.</td>
</tr>
<tr>
<td>Subscriber</td>
<td>Recipient/Beneficiary</td>
<td>The individual who is enrolled in Medicaid and receives services.</td>
</tr>
<tr>
<td>Billing/Pay-to Provider</td>
<td>Provider</td>
<td>A hospital, nursing facility, physician or dentist that submits claims to be reimbursed for care they provide to patients (subscribers).</td>
</tr>
</tbody>
</table>
# HIPAA EDI Terminology

<table>
<thead>
<tr>
<th>HIPAA ANSI X12 Term</th>
<th>Medicaid Term (if applicable)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transaction</td>
<td></td>
<td>The exchange of information between two parties to carry out financial or administrative activities related to health care.</td>
</tr>
<tr>
<td>Loop</td>
<td></td>
<td>A repeating section in an EDI transaction.</td>
</tr>
<tr>
<td>Segment</td>
<td></td>
<td>A group of related data elements within an EDI transaction.</td>
</tr>
<tr>
<td>Simple Data Element</td>
<td></td>
<td>The smallest unit of information in an EDI transaction.</td>
</tr>
<tr>
<td>Composite Data Element</td>
<td></td>
<td>A more complex unit containing two or more simple data elements.</td>
</tr>
<tr>
<td>Delimiter</td>
<td></td>
<td>A character used to separate data elements in an EDI transaction.</td>
</tr>
<tr>
<td>Qualifier</td>
<td></td>
<td>A data element that describes the type of information that is to follow in an EDI segment.</td>
</tr>
</tbody>
</table>
Transaction Overview
HIPAA Transactions

- Transactions prior to treatment
  - Eligibility Verification (270/271)
  - Authorization/Referral (278)

- Claims and related transactions
  - Claims (837)
  - Remittances (835)
  - Claim Status (276/277)

- Managed care transactions
  - Enrollment (834)
  - Premium Payment (820)
  - Encounter (837)
Prior to Treatment Transactions

Health Care Providers

270 – Eligibility Benefit Request
278 – Authorization/Certification Request
271 – Eligibility Benefit Response
278 – Authorization/Certification Response

MDCH
Claim-Related Transactions

Health Care Providers

Billing

276 – Claim Status Request
277 – Claim Status Response
835 – Claim Payment

837 – Claim

Claims Adjudication

MDCH
270/271 Eligibility Benefit Inquiry and Response
MDCH Eligibility Verification System

- MDCH currently contracts with outside entities to manage eligibility verification on behalf of the Department.

- MDCH provides these contractors with eligibility files and updates on a 6-month, weekly or daily schedule.

- Eligibility files include information for: Title XIX, Title V, MOMS, and Delta Dental Preferred and Premier beneficiaries.

- Eligibility files also include: Provider file, Managed Care Provider file, Other Insurance Coverage file and MDCH Carrier file.
MDCH Eligibility Verification System

Medicaid enrolled providers currently request eligibility verification from MDCH contractors through a variety of products, including:

- Automated Voice Response System with Voice or Fax Back Response
- Electronic Data Interchange (EDI)
  - PC Based Eligibility Verification System (EVS)
  - Browser Based EVS
  - Point of Service EVS
270/271 Overview
270/271 Overview

- The 270 is used by a provider to request eligibility, coverage, and benefit information from a payer.

- The 271 is used by the payer to respond to a provider’s request for eligibility, coverage, and benefit information.
MDCH 270/271 Transaction

Goal is to implement a HIPAA 271 transaction that:
- Supports current MDCH eligibility verification business practices
- Provides consistency across all MDCH eligibility contractors

Contractors currently receiving MDCH eligibility files and reporting eligibility and benefit information to providers:
- Medifax
- HDX
- Netwerkes.com
270/271 Transaction Detail
270 Request Transaction Structure

ST 270
Transaction Set Header

Table 2 -- Detail

2000A — Information Source
2100A — Information Source Name

2000B — Information Receiver
2100B — Information Receiver Name

2000C — Subscriber
2100C — Subscriber Name
2110C — Subscriber Eligibility or Benefit Inquiry Information

2000D — Dependent
2100D — Dependent Name
2110D — Dependent Eligibility or Benefit Inquiry Information

SE 270
2000A Information Source

- MDCH
  - Payer Identification Number (D00111)
2000B Information Receiver

- Provider
  - Provider Identification Number (Medicaid Provider ID)
  - Provider Contact Information
2000C Subscriber

- Subscriber name
- Subscriber member identification number
  - Medicaid Recipient ID
- Subscriber additional identification
  - Social Security Number
- Subscriber date of birth
- Eligibility, service or admission dates
- Service type code (eligibility request)
# 271 Response Transaction Structure

## ST 271

### Transaction Set Header

### Table 2 Detail

#### 2000A — Information Source
- 2100A — Information Source Name

#### 2000B — Information Receiver
- 2100B — Information Receiver Name

#### 2000C — Subscriber
- 2100C — Subscriber Name
- 2110C — Subscriber Eligibility or Benefit Information
  - 2115C — Subscriber Eligibility or Benefit Additional Information
  - 2120C — Subscriber Benefit Related Entity Name

#### 2000D — Dependent
- 2100D — Dependent Name
- 2110D — Dependent Eligibility or Benefit Information
  - 2115D — Dependent Eligibility or Benefit Additional Information
  - 2120D — Dependent Benefit Related Entity Name
2000A  Information Source

- MDCH
  - Payer Identification Number (D00111)
2000B Information Receiver

- Provider

  - Provider Identification Number (Medicaid Provider ID)
  - Contact Information
2000C Subscriber

- Subscriber name
- Subscriber member identification number (Medicaid Recipient ID)
- FIA worker load number
- FIA case number
- FIA county office phone number
- Patient account number (if sent in 270)
- Subscriber address, including county code and name
- Subscriber date of birth, gender
2000C Subscriber  (continued)

- Eligibility begin and end dates
- Specific eligibility or benefit information
  - Active, Inactive, Spend Down, Limitations, Other or Additional Payer, etc.
  - Coverage Level (Individual, Family, Dependents Only, etc.)
  - Service Type Code (General Benefits, Dental Care, Maternity, Emergency Services, etc.)
  - Insurance Type Code (Medicaid, HMO, Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Medicare Part A, Medicare Part B, Commercial, etc.)
  - Scope, Coverage, Level of Care, Program and Healthy Kids Dental District Codes
  - Long term care co-pay or deductible amounts
2000C Subscriber (continued)

- SMP eligibility authorization on file
- CSHCS provider authorized/not authorized
- Medicare Health Insurance Claim (HIC) number or other insurance group number (if applicable)
- Subscriber benefit related entity name, identification number and contact information
  - Medicaid, SMP or CSHCS health plan information
# 2000D Dependent

<table>
<thead>
<tr>
<th>Information</th>
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<tbody>
<tr>
<td>Dependent name</td>
</tr>
<tr>
<td>Dependent member identification number</td>
</tr>
<tr>
<td>Other payer contract number</td>
</tr>
<tr>
<td>Other payer policy number</td>
</tr>
<tr>
<td>Specific eligibility and benefit information</td>
</tr>
<tr>
<td>Benefit coverage dates</td>
</tr>
<tr>
<td>Other payer name and telephone number</td>
</tr>
</tbody>
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Questions and Answers