

Definitions of Data Elements Provided by CMS On The 271
3/28/03

CMS will return five types of 271 responses. The risk indicators for mammography, glaucoma, colorectal, prostate, pelvic, and pap, which were listed in CR2576, are removed from this list since they are no longer displayed or mapped in the 271. The 5 types of 271 responses are based upon the type of provider requesting the eligibility. Every provider will receive the Basic Provider response, except for Psychiatric Providers, Home Health Facilities and Medicare MCO's. The responses for the Basic Provider, Psychiatric Provider, Home Health Provider, MCO Inquiring On Eligibility and MCO Inquiring On Utilization will contain the following data elements:

Basic Provider:

Contractor Number – The Medicare intermediary or carrier number.

Provider Number - The Medicare provider number requesting the 270.

Requester ID - The ID of the requester.

Date & Time Stamp - The date and time that the 270 was submitted.

Surname - The first six characters of the beneficiary's last name.

First Initial – The first initial of the beneficiary.

HICN – The health insurance claim number assigned to the beneficiary.

Corrected HICN – The corrected health insurance claim number of the beneficiary, if applicable.

Zip Code – The zip code of the beneficiary.

Date of Birth – The date of birth of the beneficiary.

Date of Death – The date of death of the beneficiary.

Sex Code – The sex code of the beneficiary.

Applicable Date – The specific date listed in the 270 file.

Current Part A Entitlement Date – A date that indicates the start of current entitlement to Medicare Part A benefits.

Current Part A Terminate Date – A date that indicates the termination of current entitlement Medicare Part A benefits.

Current Part B Entitlement Date – A date that indicates the start of current entitlement to Medicare Part B benefits.

Current Part B Termination Date – A date that indicates the termination of current entitlement to Medicare Part B benefits.

Managed Care Plan ID Code – The code of the Medicare managed care plan issued by the Centers for Medicare and Medicaid Services (CMS).

Managed Care Plan Option Code – The one digit code that describes the beneficiary's relationship with the MCO, and who is responsible for processing the beneficiary's claim. The option codes are listed below which will be returned on the 271 in loop 2110, EB05.

1 - Intermediary to process all Part A and Part B claims.

2 – MCO to process claims for directly provided services and for services from providers with effective arrangements, the intermediary will process all other claims.

A – Intermediary to process all Part A and Part B provider claims.

B – MCO to process claims only for directly provided services.

C – MCO to process all claims.

Managed Care Plan Entitlement Date - A date that indicates the start of enrollment to the MCO.

Managed Care Plan Termination Date – A date that indicates the termination of enrollment to the MCO.

Other Program Entitlement:

a. Workers Compensation – Code value '15'.

b. Black Lung – Code value '41'.

MSP Data (can occur up to 5 times) – Medicare Secondary Payer, coverage that has primary responsibility over Medicare for the payment of the beneficiary's medical claims.

a. MSP Code – The code identifying why Medicare is secondary.

• Working Aged – Code value '12'.

• End Stage Renal Disease (ESRD) – Code value '13'.

• No Fault, including auto/other insurance – Code value '14'.

• Worker's Compensation – Code value '15'.

• PHS, other Federal agency – Code value '16'.

• Black Lung – Code value '41'.

• Veteran's Affairs – Code value '42'.

• Disabled beneficiary under 65 with large Group Health coverage – Code value '43'.

• Any liability insurance – Code value '47'.

b. MSP effective date – A date that indicates the start of the primary insurance coverage.

c. MSP termination date – A date that indicates the termination of the primary insurance coverage.

d. MSP insurer's name – The name of the insurance company.

e. MSP insurer's address – The address of the insurance company.

f. MSP insurer's city, state, zip – The city, state and zip code of the insurance company.

Lifetime Reserve Days – Extra days of care that may be used once all days of care in a benefit period are exhausted.

Part A Spell Data – A benefit period.

a. Hospital days remaining – The amount of hospital days remaining in the spell.

b. Co-insurance hospital days remaining – The amount of co-insurance hospital days remaining.

c. SNF days remaining – The amount of skilled nursing facility days remaining.

d. Co-insurance SNF days remaining – The amount of co-insurance SNF days remaining.

- e. Inpatient deductible remaining – The amount of the inpatient deductible remaining.
- f. Date of earliest billing action – The first date of the spell or period in which a service was performed.
- g. Date of latest billing action – The last date of the spell or period that a service was performed.

Part B Spell Data – A benefit period.

- a. Most recent Part B year – The current year of Part B services.
- b. Part B cash deductible remaining – An amount of money the beneficiary has remaining for that calendar year in order to meet the deductible.
- c. Part B physical/speech therapy limit remaining – An amount of money the beneficiary has remaining for that benefit period.
- d. Part B occupational therapy limit remaining – An amount of money the beneficiary has remaining for that benefit period.

Hospice Data:

Hospice Period Number – The chronological number of the hospice period elected by the beneficiary will be displayed on the ELGA or ELGB screen.

Hospice Start Date – The start date of a beneficiary’s elected period of hospice coverage.

Hospice Termination Date – The termination date of a beneficiary’s elected hospice coverage.

Pap Data:

Pap Date – A date that the Pap Smear (Papanicolaou test) was performed. Loop 2110C, MSG01 in the 271 file will contain either ‘pap high risk’ or ‘pap normal risk’.

Mammography Data:

Mammography Date - The dates that the mammography was performed. Loop 2110C, MSG01 in the 271 file will contain ‘mammo high risk’ or ‘ mammo normal risk’.

Technical or professional - A code that indicates whether the mammography performed was technical or professional. Loop 2110C, MSG01 in the 271 file will contain either ‘ mammo high risk’ or ‘ mammo normal risk’.

Screening Data:

Glaucoma Data:

- a. Technical or professional – A code that indicates whether the glaucoma screening performed was technical or professional.
- b. Recent dates – The dates for which the screening was performed

Colorectal Data:

- a. Technical or professional – A code that indicates whether the colorectal screening performed was technical or professional.
- b. Recent Dates – The dates for which the screening was performed.

Prostate Data:

- a. Technical or professional – A code that indicates whether the prostate screening performed was technical or professional.
- b. Recent dates – The dates for which the screening was performed.

Pelvic Risk Indicator:

- a. Technical or professional – A code that indicates whether the screening performed was technical or professional.
- b. Recent dates – The dates for which the screening was performed.

ESRD Data – End Stage Renal Disease (ESRD) that is severe enough to require dialysis or a kidney transplant.

ESRD First Code - A one-digit code that indicates the type of ESRD reimbursement method. Valid code values are:

- 1 – Reimbursement Method 1
- 2 – Reimbursement Method 2

ESRD Effective Date – The date ESRD benefits began.

Transplant Indicator – A code that indicates whether or not the beneficiary has received a Medicare covered transplant. Valid code values are:

- 1 – Allograft bone marrow – transplant from another person
- 2 – Autograft bone marrow – transplant from beneficiary
- B – Lung transplant
- C – Heart and lung transplant
- H – Heart transplant
- I – Intestinal transplant
- K – Kidney transplant
- L – Liver transplant

Transplant Discharge Date - The date the beneficiary was discharged from a hospital stay during which the indicated transplant occurred.

HHEH Data (current two episodes) - Home Health Episode

- a. HHEH start date – The date that the home health episode started. (may be used for consolidated billing)
- b. HHEH end date – The date that the home health episode terminated. (may be used for consolidated billing)
- c. HHEH date of earliest billing action – The first date of the period in which a service was performed.
- d. HHEH date of latest billing action – The last date of the period in which a service was performed.

HHBP Data (current two episodes) - Home Health Benefit Period

- a. HHBP start date - The date that a home health benefit period started
- b. HHBP end date - The date that a home health benefit period terminated.

Psychiatric provider:

All psychiatric providers will receive the basic provider data set plus the following additional data elements:

Lifetime psychiatric days remaining – The amount of lifetime psychiatric days remaining.
Part B psych limit remaining. – The amount of Medicare Part B psychiatric days remaining

The Common Working File (CWF) will identify Institutional psychiatric providers by the '4' in the third digit of the provider number.

Home Health provider:

All home health providers will receive the following data set:

Contractor Number – The Medicare intermediary or carrier number.

Provider Number - The Medicare provider number requesting the 270.

Requester ID – The ID of the requester.

Date & Time Stamp - The date and time that the 270 was submitted.

Surname - The first six characters of the beneficiary's last name.

First Initial – The first initial of the beneficiary.

HICN – The health insurance claim number assigned to the beneficiary.

Corrected HICN – The corrected health insurance claim number of the beneficiary, if applicable.

Date of Birth – The date of birth of the beneficiary.

Date of Death – The date of death of the beneficiary.

Sex Code – The sex code of the beneficiary.

Applicable Date – The specific date listed in the 270 file.

Current Part A Entitlement Date – A date that indicates the start of current entitlement to Medicare Part A benefits.

Current Part A Terminate Date – A date that indicates the termination of current entitlement Medicare Part A benefits.

Current Part B Entitlement Date – A date that indicates the start of current entitlement to Medicare Part B benefits.

Current Part B Termination Date – A date that indicates the termination of current entitlement to Medicare Part B benefits.

Managed Care Plan ID Code – The code of the Medicare managed care plan issued by the Centers for Medicare and Medicaid Services (CMS).

Managed Care Plan Option Code – The one digit code that describes the beneficiary's relationship with the MCO, and who is responsible for processing the beneficiary's claim. The option codes are listed below which will be returned on the 271 in loop 2110, EB05.

1 - Intermediary to process all Part A and Part B claims.

2 – MCO to process claims for directly provided services and for services from providers with effective arrangements, the intermediary will process all other claims.

A – Intermediary to process all Part A and Part B provider claims.

B – MCO to process claims only for directly provided services.

C – MCO to process all claims.

Managed Care Plan Entitlement Date - A date that indicates the start of enrollment to the MCO.

Managed Care Plan Termination Date – A date that indicates the termination of enrollment to the MCO.

Other Program Entitlement:

c. Workers Compensation – Code value '15'

d. Black Lung – Code value '41'

MSP Data (can occur up to 5 times) – Medicare Secondary Payer, coverage that has primary responsibility over Medicare for the payment of the beneficiary's medical claims.

a. MSP Code – The code identifying why Medicare is secondary.

- Working Aged – Code value '12'

- End Stage Renal Disease (ESRD) – Code value '13'

- No Fault, including auto/other insurance – Code value '14'

- Worker's Compensation – Code value '15'

- PHS, other Federal agency – Code value '16'

- Black Lung – Code value '41'

- Veteran's Affairs – Code value '42'

- Disabled beneficiary under 65 with large Group Health coverage – Code value '43'

- Any liability insurance – Code value '47'

b. MSP effective date – A date that indicates the start of the primary insurance coverage.

c. MSP termination date – A date that indicates the termination of the primary insurance coverage.

Hospice Data: (last four occurrences) – The beneficiary may elect Hospice benefits, providing the beneficiary is terminally ill.

The following will be returned on the 271 in loop 2110C MSG01:

a. Hospice period number - The Hospice period number will be indicated in a MSG segment of the 271 file or on the ELGA screen.

b. Hospice start date – The date that the Hospice benefits began.

c. Hospice termination date – The date that the Hospice benefits terminated.

d. Provider Number - The provider number of the Hospice facility.

e. Intermediary Number – The intermediary number

HHEH Data (current two episodes): Home Health Episode History

a. HHEH start date – The date that the episode started. (may be used for consolidated billing)

b. HHEH end date – The date that the episode terminated. (may be used for consolidated billing)

c. HHEH date of earliest billing action - The first date of the period in which a service was performed.

- d. HHEH date of latest billing action – The first date of the period in which a service was performed.
- e. Patient Status – A code that indicates the patient’s status as of the statement covers thru date.
 - Value '01'. – Discharged to home or self care (routine discharge)
 - Value '03'. - Discharged/transferred to a Skilled Nursing Facility (SNF)
 - Value '04'. - Discharged/transferred to an intermediate care facility
 - Value '05'.- Discharged/transferred to another type of institution
 - Value '06'. – Discharged/transferred to home under the care of an organized Home Health service organization
 - Value '07'.- Left against medical advice
 - Value '20'.- Patient expired
 - Value '30' – Still patient.
- f. Cancel Indicator – A code that indicates whether or not the claim has been canceled.
 - Value ‘0’ – Not cancelled
 - Value ‘1’ - Cancelled
- g. Intermediary Number – The Medicare intermediary number.
- h. HHEH provider number – The Home health provider number

HHBP Data (current two periods): - Home Health Benefit Period

- a. HHBP A visits remaining – The number of visits remaining.
- b. HHBP B visits applied – The number of visits applied.
- c. HHBP earliest billing date – The first date of the period in which a service was performed.
- d. HHBP latest billing date – The last date of the period in which a service was performed.

MCO Inquiring About A Non-Member Of The MCO:

Contractor Number – The Medicare contractor number.

Provider Number (Managed Care Plan ID) – The Medicare managed care plan ID code.

Requester ID – The ID of the requester.

Date & Time Stamp – The current date and time that the file was submitted.

Surname – The first six characters of the beneficiary’s last name.

First Initial – The first initial of the beneficiary.

HICN – The health insurance claim number assigned to the beneficiary.

Corrected HICN – The corrected health insurance claim number assigned to the beneficiary, if applicable.

Date of Birth – The date of birth of the beneficiary.

Date of Death – The date of death of the beneficiary.

Sex Code – The sex code of the beneficiary.

Applicable Date – The specific date on the 270 file

County/State Code – The county and state where the beneficiary resides.

Current Part A Entitlement/Termination Date – A date that indicates the start of current entitlement to Medicare Part A benefits and the date that indicates the termination of current entitlement to Medicare Part A benefits.

Current Part B Entitlement/Termination Date – A date that indicates the start of current entitlement to Medicare Part B benefits and the date that indicates the termination of current entitlement to Medicare Part B benefits.

MSP Data (can occur up to 5 times) – Medicare Secondary Payer, coverage that has primary responsibility over Medicare for the payment of the beneficiary’s medical claims.

- a. MSP Code – The code identifying why Medicare is secondary.
 - Working Aged – Code value ‘12’.
 - End Stage Renal Disease (ESRD) – Code value ‘13’.
 - No Fault, including auto/other insurance – Code value ‘14’.
 - Worker’s Compensation – Code value ‘15’.
 - PHS, other Federal agency – Code value ‘16’.
 - Black Lung – Code value ‘41’.
 - Veteran’s Affairs – Code value ‘42’.
 - Disabled beneficiary under 65 with large Group Health coverage – Code value ‘43’.
 - Any liability insurance – Code value ‘47’.
- b. MSP effective date – A date that indicates the start of the primary insurance coverage.
- c. MSP termination date – A date that indicates the termination of the primary insurance coverage.
- d. MSP insurer’s name – The name of the insurance company.
- e. MSP insurer’s address – The address of the insurance company.
- f. MSP insurer’s city, state, zip – The city, state, and zip code of the insurance company.
- g. Validity/delete indicator – A code that indicates the beneficiary had valid primary coverage under another insurer. Valid values are ‘Y’ for yes and ‘N’ for deleted.
- h. Original contractor – The identification number of the Medicare contractor who established the MSP record. Loop 2110C, MSG01 in the 271 file will contain the original contractor number.
- i. Updating contractor – The identification number of the Medicare contractor who last updated the MSP record. Loop 2110C, MSG01 in the 271 file will contain the updated contractor number.
- j. Date of accretion – The date that the MSP record was established.
- k. Policy number – The primary insuring organization’s policy number for the Medicare beneficiary.
- l. Group number – The primary insuring organization’s group number for the Medicare beneficiary.
- m. Group name – The primary insuring organization’s group name for the Medicare beneficiary.
- n. Maintenance date – The date in which the MSP record was modified.

- o. Insurer type – A code that indicates the source of the beneficiary’s primary insurance. The valid codes are:
- A – Insurance or indemnity
 - B – MCO
 - C – Preferred provider organization
 - D – Third party administrator arrangement under an administrative service only contract without stop loss from any entity
 - E – Third party administrator arrangement with stop loss insurance issued from any entity.
 - F – Self-insured/self administered
 - G – Collectively-bargained health and welfare
 - H – Multiple employer health plan with at least one employer who has more than 100 full and/or part-time employees.
 - I – Multiple employer health plan with at least one employer who has more than 20 full and/or part-time employees.
 - J – Hospitalization only plan, which covers only inpatient services.
 - K – Medicare services only plan which covers only non-inpatient services.
 - M – Medicare supplemental plan: Medigap, Medicare wraparound plan or Medicare carve out plan

Hospice Data (last 4 occurrences):

Hospice period number – The chronological number of the hospice period elected by the beneficiary.

Hospice start date – The start date of a beneficiary’s elected period of hospice coverage.

Hospice termination date – The termination date of a beneficiary’s elected hospice coverage

ESRD Data – End Stage Renal Disease (ESRD) that is severe enough to require dialysis or a kidney transplant.

MCO Inquiring About A Member Of The MCO:

In addition to the data in the MCO eligibility response above, the following data elements will be furnished as applicable:

Lifetime Reserve Days – Extra days of care that may be used once all days of care in a benefit period are

Lifetime Psychiatric Days remaining – Extra days of care that may be used once all days of care in a benefit period are exhausted.

HHBP Data (current two episodes): Home Health Benefit Period

a. HHBP A visits remaining – The number of visits remaining.

b. HHBP B visits applied – The number of visits applied.

c. HHBP earliest billing date – The first date of the period in which a service was performed.

d. HHBP latest billing date – The last date of the period in which a service was performed.

Part A Spell Data – A benefit period.

- a. Hospital days remaining – The amount of hospital days remaining in the spell.
- b. Co-insurance hospital days remaining – The amount of co-insurance hospital days remaining.
- c. SNF days remaining – The amount of skilled nursing facility days remaining.
- d. Co-insurance days remaining – The amount of co-insurance SNF days remaining.
- e. Inpatient deductible remaining – The amount of the inpatient deductible remaining.
- h. Date of earliest billing action – The first date of the spell or period in which a service was performed.
- i. Date of latest billing action – The last date of the spell or period that a service was performed.