CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 793

Department of Health & Human Services (DDHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 29, 2005

Change Request 4193

SUBJECT: Revision to Chapter 31 - Addition of Hospice Data HIPAA 270/271 Eligibility

NOTE: Transmittal 791, dated December 23, 2005 is rescinded and replaced with Transmittal 793, dated December 29, 2005. The manual instruction was inadvertently left off the original issuance of the document. All other information remains the same.

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services (CMS) is making changes to its information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 23, 2006

IMPLEMENTATION DATE: January 23, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	31/10.2/Eligibility Extranet Workflow

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

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SUBJECT: Revision to Chapter 31 – Addition of Hospice data to HIPAA 270/271 Eligibility

NOTE: Transmittal 791, dated December 23, 2005 is rescinded and replaced with Transmittal 793, dated December 29, 2005. The manual instruction was inadvertently left off the original issuance of the document. All other information remains the same.

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) is making changes to its Information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response in real-time.

B. Policy: This CR will support the Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4193.1	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 23, 2006 **Implementation Date:** January 23, 2006 **Pre-Implementation Contact(s):** Kim Suhr Kim.Suhr@cms.hhs.gov(410)786-1023 **Post-Implementation Contact(s):** Kim Suhr Kim.Suhr@cms.hhs.gov(410)786-1023	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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Medicare Claims Processing Manual
Chapter 31 - ANSI X12N Formats Other than Claims or Remittance

10.2 - Eligibility Extranet Workflow

(Rev. 793, Issued: 12-29-05, Effective/Implementation: 01-23-06)

The Centers for Medicare and Medicaid Services (CMS) is making changes to its Information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized HIPAA compliant 270/271 health care eligibility inquiry and response in real-time.

The CMS is using a phased approach for providing this eligibility transaction on a real-time basis:

1. Extranet: In June of 2005, Clearinghouses, certain providers and trading partners (as described below) will be permitted to submit 270s via the CMS AT&T communication Extranet (the Medicare Data Communication Network or MDCN). This Extranet is a secure closed private network currently used to transmit data between Medicare Fee-for-Service (FFS) contractors and CMS.

2. Internet: We expect to provide limited internet access to the 270/271 transaction later this year. Instructions on accessing eligibility data via this method will be provided prior to the time internet access becomes available.

All electronic 270 files will be processed at the CMS data center. The CMS data center will use a single consolidated national eligibility database to respond to the eligibility inquiries.

Access Process for Clearinghouses/Provider

September 1, 2005 all submitters who have been authenticated by CMS to conduct 270/271 transactions with CMS will be required to complete a TRADING PARTNER AGREEMENT FOR SUBMISSION OF 270s TO MEDICARE ON A REAL-TIME BASIS. This agreement outlines security and privacy procedures for the submitters requesting access to the Medicare beneficiary database. The Medicare Eligibility Integration Contractor (MEIC) will transmit via e-mail the TRADING PARTNER

AGREEMENT FOR SUBMISSION OF 270s TO MEDICARE ON A REAL-TIME BASIS to each authenticated submitter. Each submitter should complete the form in its entirety and transmit it back via e-mail to MCAREHD@emdeon.com.

Starting October 1, 2005 In order to obtain access to the CMS 270/271 Medicare Eligibility transaction via the MDCN a Submitter will access the appropriate forms at WWW.CMS.HHS.GOV/IT. The first form to be completed is the TRADING PARTNER AGREEMENT FOR SUBMISSION OF 270s TO MEDICARE ON A REAL-TIME BASIS. This agreement outlines security and privacy procedures for the submitters requesting access to the Medicare beneficiary database. The submitter must electronically provide the information requested on the form and click on the appropriate assurances. If Submitter does not consent to the terms of the agreement, by appropriately completing the form the access process will be terminated.

If Submitter checks the appropriate boxes of the agreement and supplies the information requested, a copy of the completed form will be electronically submitted to the CMS 270/271 Medicare Eligibility Integration Contractor (MEIC) for security authentication. The access process will then continue, and the Submitter will be directed to complete an MDCN connectivity form and submit it electronically in order to be connected to the 270/271 eligibility database.

CMS staff will ensure that all of the necessary information is provided on the form, as well as ensure the complete connectivity to the 270/271 application. The MEIC will be responsible for contacting the Clearinghouses, providers, and trading partners to authenticate the accessing entity's identity. Once authentication has been completed, the MEIC will provide the Clearinghouses, Providers, and Trading Partners with a submitter ID that is required to be used on all 270/271 transactions. Testing will be coordinated by the MEIC. After successful testing, 270 production inquiries may be sent real-time. Please note that in order to access the MDCN, an entity must on its own obtain the necessary telecommunication software from the AT&T reseller.

The current AT&T resellers and contact numbers are listed below:

IVANS: www.ivans.com

1-800-548-2675

McKesson: www.mckesson.com

1-800-782-7426, option 5, then key option 8

Helpdesk Support

The MEIC will provide help desk support during the hours of 7:00am - 9:00pm eastern time Monday through Friday. The phone number is: 1-866-324-7315. The email address for the helpdesk is: MCARE@cms.hhs.gov.

Telecommunications Wrapper

Communications through the extranet to the CMS data center will be via the TCP/IP streaming socket protocol. Trading Partners can submit multiple 270 transactions; it will not be necessary to wait for a response before triggering the next 270. Trading partners must ensure that the session remains connected until all responses are received. Each submitted transmission shall contain one 270 transaction with only one ISA and IEA segment, along with a transmission wrapper around the 270 transaction. There will be no handshake after the connection is accepted with the first submitted transmission.

Outbound response transactions will have the same format transmission wrapper. The response to the submitter will be returned in the same session in which the 270 was submitted.

Standard format of the TCP/IP Transaction Wrapper:

SOHLLLLLLLLLLSTX<HIPAA 270 Transaction>ETX

SOH = Required (1 position), must be EBCDIC or ASCII - 01

LLLLLLLLLL = Required (10 positions), Right justified with zero padded

Note: Length of the HIPAA 270 transaction not including Transmission wrapper data.

STX = Required (1 position), must be EBCDIC or ASCII - 02

<HIPAA 270 Transaction> = Required (HIPAA 270 - ISA - IEA),

ETX = Required (1 position), Must be EBCDIC or ASCII -03

NOTE: For more detail about SOH, STX and ETX, see the Health Care Eligibility Benefit Inquiry and Response 270/271 ASC X12 Extended Control Set.

270 Inquiry Requirements

The ISA08 (interchange receiver id) and the GS03 (application receiver's code) on the 270 transactions must contain "CMS", left justified space filled.

CMS will return certain data elements on the 271 response only when certain service type codes are sent on the 270. Other core data elements will be included in each 271 response, regardless of service type codes, when applicable. Both the core and the additional data elements are listed below.

CMS will utilize the search option as listed in the 270/271 implementation guide (section 1.3.8) requiring the patient's member id (HIC number), patient's full first name, patient's full last name, and patient's date of birth.

Proprietary Error Messages

Proprietary error messages will be sent only when the ISA segment of the 270 transaction cannot be read making it impossible to formulate an ISA segment for the response. The format of the proprietary message is described below:

Description	Content	Size	Comments
Transaction	Transaction ID	04 characters	"HETS"
Transaction Reference Number	Reference #	30 characters	Reference Number for tracking
Date Stamp	System Date	08 Characters	CCYYMMDD
Time Stamp	System time	09 Characters	HHMMSSSSS
Response Code	Error Code	02 Characters	See Below
	ISA Response code	" I"	Incoming ISA cannot be read
	Delimiter Response code	" D"	Delimiter could not be identified
Message Code	Error Code	08 Characters	Error code
Message Text Description	Error Descriptions	70 Characters	Description of error

271 Response Data Elements

If a service type code is submitted in a 270 that does not trigger additional Medicare data elements, the following data elements will be returned in the 271 as applicable:

271 INFORMATION RETURNED	LOOP	SEGMENT	ELEMENT	DATA VALUE
Part A/B Entitlement/Term Dates	2110C	EB	EB01 EB02 EB04	1 IND MB or MA

	2110C	DTP	DTP01 DTP02 DTP03	307 RD8 or D8 Date(s)
Beneficiary Address	2100C	N3 N4	N301 N302 N401 N402 N403	Address Address City State Code Zip Code
Deductible - Part B	2110C	EB	EB01 EB03 EB04 EB06 EB07	C 96 MB 29 Amount
	2110C	DTP	DTP01 DTP02 DTP03	292 RD8 Applicable Calendar Year
MCO Data	2110C	EB	EB01 EB03 EB04	R 30 HN
	2110C	REF	REF01 REF02	18 MCO ID

	2110C	DTP	DTP01 DTP02 DTP03	290 RD8 or D8 Date(s)
	2120C	NM1	NM101 NM102 NM103	PRP 2 Insurer Name
	2120C	N3	N301 N302	Address Address
	2120C	N4	N401 N402 N403	City State Code ZIP Code
MSP Data	2110C	EB	EB01 EB02 EB03 EB04	R Ind 30 12, 13, 14, 15, 16, 41, 42, 43, 47
	2110C	REF	REF01 REF02	IG Policy Number
	2110C	DTP	DTP01 DTP02 DTP03	290 RD8 or D8 Date(s)
	2120C	NM1	NM01 NM102	PRP 2

			NM103	Name
	2120C	N3	N301	Address
			N302	Address
	2120C	N4	N401	City
			N402	State Code
			N403	Zip Code
Home Health Data	2110C	EB	EB01	X
			EB03	42
			EB04	MA
			EB06	26
	2110C	DTP	DTP01	193 or 194
			DTP02	D8
			DTP03	Date(s)
	2110C	MSG	MSG01	HHEH Start Date
				HHEH End Date
				HHEH DOEBA
				HHEH DOLBA
Hospice Data	*2110C*	*EB*	*EB01*	*X*
			EB03	*45*
			EB04	*MA*
			EB06	*26*
		DTP	*DTP01*	*292*
			DTP02	*D8 or RD8*
			DTP03	*Dates*

If one or more of the following service type codes are submitted in a 270, the following additional data elements will be returned in the 271, as applicable.

Service Type Code	LOOP	SEGMENT	ELEMENT	DATA VALUE
14	2110C	EB	EB01	D
			EB03	14
			EB04	MB
	2110C	DTP	DTP01	356
			DTP02	D8
			DTP03	Date
	2110C	DTP	DTP01	198
			DTP02	D8
			DTP03	Date
	2120C	MSG	MSG01	Transplant Discharge Date
15	2110C	EB	EB01	D
			EB03	15
			EB04	MA
	2110C	DTP	DTP01	356
			DTP02	D8
			DTP03	Date
	2110C	DTP	DTP01	198
			DTP02	D8

			DTP03	Date
	2120C	MSG	MSG01	Transplant Discharge Date
42	2110C	EB	EB01	X
			EB03	42
			EB04	MA
	2120C	NM1	NM101	PR
			NM102	2
			NM103	Name of RHHI
			NM108	PI
			NM109	00011, 00180, 00380, 00450, 00454
	2120C	PRV	PRV01	HH
			PRV02	9K
			PRV03	Provider number
47	2110C	EB	EB01	C
		Part A Deductible	EB03	47
			EB04	MA
			EB06	29
			EB07	Amount
		DTP		
		Hospital Admission	DTP01	435
			DTP02	RD8
			DTP03	Dates

	2110C	EB Hospital Days Remaining DTP Hospital Admission	EB01 EB03 EB04 EB06 EB09 EB10 DTP01 DTP02 DTP03	F 47 MA 29 DY Days 435 RD8 Dates
	2110C	EB Co-Insurance Days Remaining DTP Hospital Admission	EB01 EB03 EB04 EB06 EB07 EB09 EB10 DTP01 DTP02 DTP03	A 47 MA 29 Amount Per Day DY Days 435 RD8 Dates
	2110C	EB Lifetime Reserve Days	EB01 EB03	K 47

			EB04	MA
			EB06	33
			EB09	LA
			EB10	Days
AG	2110C	EB Hospital Days Remaining	EB01	F
			EB03	47
			EB04	MA
			EB06	29
			EB09	DY
			EB10	Days
		DTP Hospital Admission	DTP01	435
			DTP02	RD8
			DTP03	Dates
	2110C	EB Co-Insurance Days Remaining	EB01	A
			EB03	47
			EB04	MA
			EB06	29
			EB07	Amount Per Day
			EB09	DY
			EB10	Days
		DTP Hospital Admission	DTP01	435
			DTP02	RD8

			DTP03	Dates
	2110C	EB Lifetime Reserve Days	EB01 EB03 EB04 EB06 EB09 EB10	K 47 MA 33 LA Days
	2110C	EB SNF Days Remaining DTP SNF Admission	EB01 EB03 EB04 EB06 EB09 EB10 DTP01 DTP02 DTP03	F AG MA 29 DY Days 435 RD8 Dates
	2110C	EB Co-Insurance SNF Days Remaining	EB01 EB03 EB04 EB06 EB07 EB09 EB10	A AG MA 29 Amount Per Day DY Days remaining

		DTP SNF Admission	DTP01 DTP02 DTP03	435 RD8 Dates