Companion Guide for 270 271

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Disclosure

The 271 Eligibility Benefit Response returned by Vaya Health (Vaya) should not be interpreted as a guarantee of payment. Payment of benefits remains subject to all health benefit plan terms, limits, conditions, exclusions, and the member's eligibility at the time services are rendered.

The information in this document is subject to change. Changes will be posted on the Claims Submission page of Vaya's Provider Central website.

Preface

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Vaya. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

The Communications/Connectivity component is included in the Companion Guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the Companion Guide when the publishing entity wants to clarify the Implementation Guides' instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASC X12's copyrights and Fair Use statement.

Transaction Instruction (TI) Introduction

Scope

This Companion Guide provides specific requirements for sending the Eligibility Benefit Inquiry to Vaya. This document provides information about the Eligibility Benefit Response using CAQH CORE compliance rules. It supplements the ASC X12N 270/271 (005010X279A1) Health Care Implementation Guide and should only be used for the purpose of clarification.

For more information about CAQH-CORE rules, go to caqh.org.

Overview

This Companion Guide must be used in conjunction with the Eligibility Benefit Inquiry/Response (270/271) instructions as set forth by the ASC X12 Standards for Electronic Data Interchange (Version 005010X279A1).

What Is CAQH?

CAQH stands for the Council for Affordable and Quality Healthcare. It is a nonprofit alliance of health plans, provider networks, and associations with a goal to provide a variety of solutions to simplify health care administration.

What Is CORE?

CORE stands for the Committee on Operating Rules for Information Exchanges. CORE consists of a group of health plans, providers, vendors, Centers for Medicare & Medicaid Services (CMS), and other government agencies, associations, regional entities, standard-setting organizations, and other health care entities that are facilitated by CAQH. CORE's goal is to create, disseminate, and maintain operating rules that enable health care providers to obtain reliable health care eligibility and benefits information quickly and securely. It will decrease the amount of time and resources providers spend verifying patient eligibility, benefits, and other administrative information at the point of care.

What Is CAQH-CORE Certification?

An entity that creates or transmits eligibility data is eligible to become CAQH-CORE certified. The entity must agree to follow the CAQH-CORE operating rules and will be expected to exchange eligibility and benefits information per the requirements of the CORE Phase II rules and policies. To view the CORE Phase II rules and policies, go to caqh.org.

References

- ASC X12 Version 5010 Implementation Guides: x12.org/products
- CAQH/CORE: caqh.org/caqh-core
- SOAP: w3.org/TR/soap12
- MIME Multipart: w3.org/Protocols/rfc1341/7_2_Multipart.html
- CORE XML Schema: caqh.org/core/eligibility-benefits-operating-rules
- Washington Publishing Company: wpc-edi.com
- ASC X12 Organization: x12.org
- U.S. Department of Health and Human Services (HHS): hhs.gov/hipaa/index.html
- Workgroup for Electronic Data Interchange (WEDI): wedi.org
- North Carolina Department of Health and Human Services: ncdhhs.gov
- NC Medicaid (Division of Health Benefits): medicaid.ncdhhs.gov
- NC Division of Public Health: ncdhhs.gov/divisions/public-health
- NC Division of Mental Health, Developmental Disabilities, and Substance Use Services: ncdhhs.gov/divisions/mhddsus

Additional Information

CAQH CORE has defined specific rules regarding Name Normalization, which pertains to normalizing the last name. The rules for Name Normalization are:

- Converting all letters to upper case
- The removal of titles/prefixes/suffixes
- The removal of 16 special characters: ! ' & ' () * + , - . / : ; ? =

- The removal of character strings (prefixes/suffixes) when they are preceded by a space, comma, or forward slash: JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ

Trading Partner Agreements

EDI Trading Partner Agreements ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement. The Trading Partner Agreement may specify, among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

To request a Trading Partner Agreement, please email the following information to EDI@vayahealth.com with the subject line "Trading Partner Agreement needed":

- Provider, clearinghouse, or billing agency's legal name
- Contact name
- Contact email address
- Contact phone number
- Address
- Federal tax ID number (EIN)
- NPI number(s)
- Clearinghouse (if used)

Testing with the Payer

Vaya requires testing, or third-party certification, prior to approving a Trading Partner to submit claims in production. Once Trading Partner claims are in production, Vaya reserves the right to require re-testing if it is determined that the Trading Partner is receiving/generating an unacceptable volume of errors.

The steps for testing with Vaya are available on the Claims Submission page of our Provider Central website.

Contact Information

For electronic data interchange (EDI) technical assistance, email EDI@Vayahealth.com

North Carolina Time Limit Override (TLO)

Questions

The recipient's eligibility dates may not be consecutive if the approved TLO has a range of dates that is more than two dates of service. Providers will not be able to check the recipient's eligibility via the X12 270/271 Eligibility Request/Response if the dates of service value is greater than 365 days. Please use the Vaya Provider Portal to check if there are additional TLO date spans or to verify the recipient's eligibility during that period.

Control Segments/Envelopes

ISA-IEA

Transactions transmitted during a session are identified by Interchange Header Segment (ISA) and Trailer Segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

GS-GE

EDI transactions of a similar nature that are destined for one trading partner may be gathered into a functional group, identified by a Functional Group Header Segment (GS) and a Functional Group Trailer Segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope.

ST-SE

The beginning of each individual transaction is identified using a Transaction Set Header Segment (ST), and the end of every transaction is marked by a Transaction Set Trailer Segment (SE).

Search Criteria

The following search criteria are supported:

Scenario	Medicaid ID	SSN	DOB	Last Name	First Name
1	X				
2		X	X		
3	X	X	X		
4	X		X	X	
5	X			X	X
6			X	X	X

Eligibility Returned

Eligibility information is returned based on the Vaya payer and the benefit plan(s) for the payer.

Vaya allows eligibility request dates to be one month in the future. Any eligibility status returned for a future month reflects the beneficiary's status at the time of the request and is subject to change. Providers should confirm eligibility before rendering services.

Range of Dates Supported for Inquiries

An eligibility inquiry may be for dates up to 36 months (prior to the current month). Requests will be limited to one to 12-month segments and 13 months if the current month is included in the request.

270 EQ Segment Formatting Requirements

The X12 270 request must have one “EQ” segment with the service types strung together. If multiple EQ segments are submitted for a single request, only the last Service Type Code requested will be returned on the 271 response.

For explicit inquiry requests, the Trading Partner may request up to five Service Type Codes. If the Trading Partner wishes to request eligibility for more than five Service Type Codes, they must use Service Type Code “30” to receive all eligibility information. The additional Service Type Codes will be ignored if more than five Service Type Codes are submitted.

The Trading Partner may not request Service Type Code “30” in addition to other Service Type Codes on the same request. If the Trading Partner submits a Service Type Code “30” in addition to other Service Types, the 271 response will default to the other Service Type Codes and will ignore Service Type code “30.”

Examples of accepted EQ segments: EQ*30~ or EQ*1^2^3^4^5~

Benefit Plans Returned

Eligibility information is only returned for Medicaid benefit plan(s). When using a date range in the search, eligibility is returned based on the start date of the range.

Eligibility information is not returned for benefit plans that are covered by the Division of MHDDSUS.

Acknowledgements

For all inbound transactions, a 999 Acknowledgement Report will be sent to the Trading Partner’s OUTBOX for retrieval. This report serves as the acknowledgement of the submission of a file. Typically, 999 Acknowledgement Reports are available within moments of submission.

Transaction-Specific Information

The following tables contain one or more rows for each segment for which a supplemental instruction is needed.

005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

Loop ID	Reference	Name	Codes	Notes/Comments
Header	ISA	Interchange Control Header		
	ISA05	Interchange ID Qualifier		Use 'ZZ'
	ISA06	Interchange Sender ID		Use the Submitter/Folder ID provided by the Vaya EDI Team
	ISA07	Interchange ID Qualifier		Use 'ZZ'
	ISA08	Interchange Receiver ID		Submitters will use '13010'
Header	GS	Functional Group Header		
	GS02	Application Sender's Code		Use the Submitter/Folder ID provided by the Vaya EDI Team
	GS03	Application Receiver's Code		13010 is used
Header	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	13	Use '13' Vaya does not support Cancellation via 270 Inquiry
2100A	NM1	Information Source Name		
	NM101	Entity Identifier Code	PR	Use 'PR'
	NM102	Entity Type Qualifier	2	Use '2'
	NM103	Name Last or Organization Name		Use '13010'
	NM108	Identification Code Qualifier	PI	Use 'PI'
	NM109	Information Source Primary Identifier		Use '13010'
2100B	NM1	Information Receiver Name		
	NM101	Entity Identifier Code	1P, 2B, GP	Use '1P', '2B', or 'GP'
	NM108	Identification Code Qualifier	SV, XX	Use 'SV' to send provider number in NM109 or 'XX' to send NPI number in NM109
2100B	PRV	Information Receiver Provider Information		
	PRV01	Provider Code	SB	Use 'SB'
	PRV03	Reference Identification		Requesting provider's Taxonomy Code
2100C	NM1	Subscriber Name		

Loop ID	Reference	Name	Codes	Notes/Comments
	NM103	Name Last or Organization Name		The Subscriber last name must be 'Normalized;' refer to Additional Information section of this Companion Guide for Name Normalization rules
2100C	REF	Subscriber Additional Identification		
	REF01	Reference Identification Qualifier	SY	Use 'SY'
2100C	PRV	Provider Information		
	PRV01	Provider Code	OT, RF	Use 'OT' or 'RF'
	PRV02	Reference Identification Qualifier	9K, HPI	Use '9K' or 'HPI'
2100C	DTP	Subscriber Date		
	DTP01	Date/Time Qualifier	291	Use '291'
	DTP02	Date Time Period Format Qualifier	RD8	Use 'D8' or 'RD8'
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
	EQ01	Service Type Code		For an explicit inquiry, Trading Partners may request up to five inbound Service Type Codes; if the Trading Partner wishes to request eligibility for more than five service types, they must use Service Type Code '30' to receive all eligibility information
2000D	HL	Dependent Level		Vaya does not support the Dependent Loop Patients are identified at the Subscriber Level (Loop 2000)

271-Specific Information

Loop ID	Reference	Name	Codes	Notes/Comments
Header	ISA	Interchange Control Header		
	ISA03	Security Information Qualifier	0	'00' is returned
	ISA05	Interchange ID Qualifier	ZZ	'ZZ' is returned
	ISA06	Interchange Sender ID		13010 is used
	ISA07	Interchange ID Qualifier	ZZ	'ZZ' is returned
	ISA08	Interchange Receiver ID		Return Provider's Electronic Transmitter Identifier Number (ETIN) (Receiver's ETIN) is returned
	ISA11	Repetition Separator	^	
	ISA14	Acknowledgment Requested	0	'0' is returned
	ISA16	Component Element Separator	:	':' is returned
Header	GS	Functional Group Header		
	GS01	Functional Identifier Code	HB	'HB' is returned
	GS02	Application Sender's Code		13010 is used
	GS03	Application Receiver's Code		Return Provider's ETIN (Receiver's ETIN) is returned
2000A	AAA	Request Validation		
	AAA01	Valid Request Indicator	N	'N' when sent
	AAA03	Reject Reason Code	42	When '42' is returned, email EDI@vayahealth.com for explanation (system down or data error)
	AAA04	Follow-up Action Code	P	'P' when sent
2100A	NM1	Information Source Name		
	NM101	Entity Identifier Code	PR	'PR' is returned
	NM102	Entity Type Qualifier	2	'2' is returned
	NM103	Name Last or Organization Name	Vaya	'VAYA' is returned
	NM108	Identification Code Qualifier	PI	'PI' is returned
	NM109	Identification Code	Vaya	'13010' is returned
2100A	PER	Information Source Contact Information		This segment is used to provide Vaya EDI contact information
	PER02	Name		'VAYA ' is returned
	PER03	Communication Number Qualifier	TE	'EM' is returned
	PER04	Communication Number		'EDI@vayahealth.com' is returned
2100A	AAA	Request Validation		
	AAA01	Yes/No Condition or Response Code	N	'N' when sent

Loop ID	Reference	Name	Codes	Notes/Comments
	AAA03	Reject Reason Code	42	When '42' is returned, email EDI@vayahealth.com for explanation (system down or data error)
	AAA04	Follow-up Action Code	P	'P' when sent
2100B	NM1	Information Receiver Name		
	NM108	Identification Code Qualifier	SV, XX	'SV' or 'XX' is returned
	NM109	Identification Code		Contains the Provider Number as submitted on the 270 request
2100B	REF	Information Receiver Additional Identification		Contains what is received on the 270 request
	REF01	Reference Identification Qualifier	JD	'JD' is returned
	REF02	Reference Identification		'432' = Combination of payer(s)
2100B	AAA	Information Receiver Request Validation		
	AAA01	Yes/No Condition or Response Code	N	'N' when sent
	AAA03	Reject Reason Code	41, 50, 51, T4, 15	Vaya will return one of the following Reject Reason Codes if the 2100B, AAA segment is sent: '41', '50', '51', 'T4;' Reject Reason Code '15' is returned when the requestor submits a 270 Eligibility request without any search options
	AAA04	Follow-up Action Code	C	'C' when sent
2100C	NM1	Subscriber Name		
	NM103	Name Last or Organization Name		The Normalized last name is returned on the NM103 segment. Refer to Additional Information Section of this Companion Guide for Name Normalization rules.
	NM108	Identification Code Qualifier	MI	'MI' is returned
	NM109	Identification Code		Recipient ID is returned
2100C	AAA	Subscriber Request Validation		
	AAA01	Yes/No Condition or Response Code	N	'N' when sent
	AAA03	Reject Reason Code		More than one AAA Reject Reason code can be received on an eligibility response; please refer to the 270/271 Health Care Eligibility Benefit Inquiry and Response Technical Report 3 (TR3) for Reject Reason Code descriptions
	AAA04	Follow-up action code	R	'R' when sent

Loop ID	Reference	Name	Codes	Notes/Comments
2100C	INS	Subscriber Relationship		The INS segment is returned to inform the Trading Partner that the Subscriber Last Name submitted in the 270 Eligibility Request, in the 2100C, NM103 segment, was 'Normalized' to search eligibility; the 'Normalized' last name is returned on the 271 Eligibility Response, in the 2100C, NM103 segment
2100C	DTP	Subscriber Date		Used when there is a single period of eligibility
	DTP01	Date Time Qualifier	291	'291' is returned
	DTP02	Date Time Period Format Qualifier	RD8	'RD8' is returned
	DTP03	Date Time Period		Eligibility period for Benefit Plan identified in EB segment
2110C	EB	Subscriber Eligibility or Benefit Information		
	EB01	Eligibility or Benefit Information Code	1	'1' when EB05 is: • MC1915 – Prior to 4/1/2023 • MCDIRECT – Medicaid Direct • MCEXPANDMD – Medicaid Direct Expansion • MC1115 – TP Medicaid Managed Care - 1115 • MCEXPANDTP – Medicaid Expansion TP • TP Innovations Waiver Managed Care Rider • 1915i Rider
	EB02	Coverage Level Code	IND	'IND' is returned
	EB03	Service Type Code		• If only one Service Type Code is returned, the recipient is only eligible for that particular service; please refer to the 2110C MSG segment for special notes • '30' when EB05 is Third Party Liability • '32' when the recipient is not eligible for Medicaid claims payment • Otherwise, Service Type values are returned appropriate for the Benefit Plan
	EB05	Plan Coverage Description		See Appendix A, 271 2110C EB05 Plan Coverage Descriptions for Vaya Plan Coverage Descriptions
	EB06	Time Period Qualifier	25, 29	'25' is used to report the contracted or allowed value
				'29' is used to report the remaining or available value

Loop ID	Reference	Name	Codes	Notes/Comments
	EB07	Monetary Amount		Used to report recipient out-of-pocket maximum limit, amount for Cost Sharing, Co-Payment, or service limit monetary value Co-pay information for the Infant Toddler Program is based on a sliding scale, which is based off the prior approval; this is by recipient and stored on the prior approval, and therefore is unknown at time of inquiry
	EB09	Quantity Qualifier	VS	'VS' is used to report the number of Service Limit visits or units
	EB10	Quantity		Reports the number of Service Limits visits or units
2110C	REF	Subscriber Additional Identification		
	REF01	Reference Identification Qualifier	18, 1L, 6P, IG	• '18' is used to report information regarding Medicare Part A & B • '1L' is used to report information regarding Medicare Part C • '6P' is used to report Insurance Policy Group ID for applicable Third-Party Liability • 'IG' is used to report Insurance Policy Number for applicable Third-Party Liability
	REF02	Reference Identification		• MBI/HIC Number is returned for Medicare Part A and B • '999' is returned for Medicare Part C. '998' is returned for Medicare Part D
	REF03	Description		• 'Medicare' is returned for Medicare Part A • 'Medicare C Health Group Org' is returned for Medicare Part C • 'Medicare D Health Group Org' is returned for Medicare Part D
	PER03	Communication Number Qualifier	TE	
	PER04	Communication Number		Used to report organizational or business phone number
	PER05	Communication Number Qualifier	TE	
	PER06	Communication Number		Used to report organizational or business after-hours phone number