Standard companion guide transaction information

Instructions related to transactions based on Accredited Standards Committee (ASC) X12 implementation guides (IGs), version 005010

270/271 – ANSI X12 version 005010X279A1

Companion guide version number: 2.0

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Humana®

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Preface

Companion guides (CGs) may contain two types of data: instructions for electronic communications with the publishing entity (communications/connectivity instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The communications/connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain a communication exchange.

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1. Introduction

Scope

This document is to be used for the implementation of the Health Insurance Portability and Accountability Act (HIPAA) 5010 Health Care Eligibility and Benefit Inquiry and Response (270/271) (referred to as "eligibility and benefit" in the rest of this document) for the purpose of submitting eligibility and benefit inquiries electronically. This companion guide is not intended to replace the Type 3 Technical Reports (TR3).

Overview

This companion guide is intended to assist you in implementing electronic eligibility and benefit transactions that meet Humana processing standards by identifying pertinent structural and data-related requirements and recommendations.

Reference

For more information regarding the ASC X12 Standards for Electronic Data Interchange 270/271 Health Care Eligibility and Benefit Inquiry and Response (005010X279A1) and to purchase copies of the TR3 documents, visit the ASC X12 store website at http://store.x12.org/store/.

Additional information

The American National Standards Institute (ANSI) is the coordinator and clearinghouse for information on national and international standards related to electronic data interchanges. In 1979, ANSI chartered the ASC X12 to develop uniform standards for electronic interchange of business transactions and to eliminate nonstandard electronic data communication. The objective of the ASC X12 is to develop standards that facilitate electronic interchange relating to all types of business transactions. The ASC X12 standards are recognized by the United States as the electronic data exchange standard for North America. Electronic data interchange (EDI) adoption has been proved to reduce the administrative burden on healthcare providers.

2. Getting started

Working with Humana

Humana currently uses Availity as its exclusive clearinghouse for managing 270/271 EDI transactions. This guide includes the instructions you will need to get connected and start sending/receiving standard 270 and 271 transactions with Availity. Please read the entire guide so you may take advantage of the full functionality of the system.

Clearinghouse connection

Physicians and health care professionals should contact their current clearinghouse vendor to discuss their ability to support the eligibility and benefit transaction, as well as associated time frames for implementation, costs, etc.

Trading partner registration

Before submitting or receiving a 270 or 271 transaction, you must register as a trading partner with Availity. For registration instructions, see:

- Availity® Health Information Network Batch Electronic Data Interchange (EDI) Standard Companion Guide: www.availity.com/documents/edi_guide.pdf

- Availity.com Specification & Design Document: Vendor Business-to-Business Specifications — Basic: support.availity.com/servlet/fileField?id=0BE60000000PKre

If you have questions not answered in the guides, please visit www.Availity.com or call 1-800-282-4548.

Certification and testing overview

Availity requires that all vendors and high-volume senders pass HIPAA compliance and integration testing before submitting transactions to Availity. This testing ensures that your translated HIPAA ASC X12 transactions can pass HIPAA standards validation and any applicable payer-specific edits that Availity performs on the payer's behalf. This testing is coordinated through the Availity Client Services Department (1-800-282-4548).

3. Testing with the payer

All testing with Humana is completed via our clearinghouse, Availity.

File submission methods

Availity offers three methods for you to send and receive transactions: secure file transfer protocol (SFTP), FTP + PGP and web upload. If you want to use SFTP, you will need to obtain a user ID and password from the Availity implementation analyst who is assisting with testing.

- SFTP – This method involves logging in to the appropriate Availity file transfer protocol (FTP) site using an SFTP client. SFTP allows you to send and receive files securely using port 9922. You do not need to log in to Availity to use SFTP. For more details on sending and receiving files using this method, please review this document:

  Availity® Health Information Network Batch Electronic Data Interchange (EDI) Standard Companion Guide: www.availity.com/documents/edi_guide.pdf

- FTP + PGP – For FTP, you must use the PGP encryption method to ensure security, provide a PGP key to Availity for decryption purposes and send the encrypted file to the appropriate Availity FTP site using an FTP application. For more details, please review this document:

  Availity® Health Information Network Batch Electronic Data Interchange (EDI) Standard Companion Guide: www.availity.com/documents/edi_guide.pdf

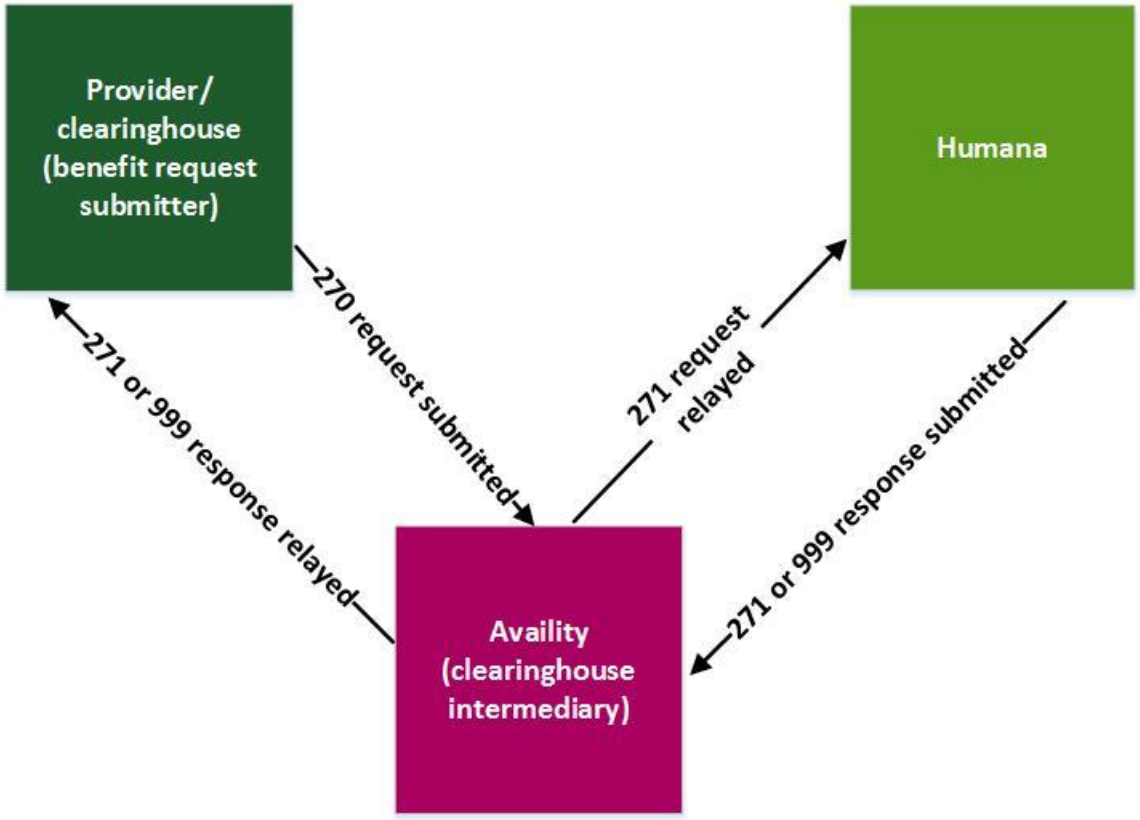
- Web upload – This method allows you to send files and receive reports, acknowledgments and transactions from Availity without installing additional software. You must have Internet access and an Availity user ID and password to use Web upload.

It is strongly recommended that you check your transactions for compliance to 005010 standards using a compliance checker.

4. Connectivity with the payer/communications

Process flow

The process flow for the 270/271 transaction exchange will involve three separate entities: Humana, the healthcare provider or clearinghouse sending the benefit request, and Availity. Availity will serve as an intermediary between the request source and Humana, exchanging the benefit request and Humana's benefit response through its secure connections with both entities.



Transmission administrative procedures

Humana will return a 271 response or 999 (in case of failed validation) within 20 seconds of receiving the 270 request from Availity to provide as close to a real-time response as possible. This response process runs 24 hours a day in order to process requests as they come in.

Retransmission procedure

Humana's real-time exchange services do not perform retransmissions. It is the trading partner's responsibility to resubmit.

Communication protocol specifications

Humana has provided connectivity that complies with the Committee on Operating Rules for Information Exchange (CORE) Safe Harbor principle (§5 Safe Harbor) according to the CORE Connectivity Phase II Rule 270, version 2.2.0 and Phase II Rule 250, version 2.1.0.

For detailed information regarding Availity's security protocol, please review this document:

Availity® Health Information Network Batch Electronic Data Interchange (EDI) Standard Companion Guide: www.availity.com/documents/edi_guide.pdf

5. Contact information

Availity Customer Service: 1-800-282-4548

6. Control segments/envelopes

For the ISA, the IEA, GS, ST, GE and SE segments, please review this document:

Availity® Health Information Network Batch Electronic Data Interchange (EDI) Standard Companion Guide: www.availity.com/documents/edi_guide.pdf

7. Payer-specific business rules and limitations

Humana's trading partners must adhere to the following business rules and limitations for submitting transactions in real time:

- Only one patient's information should be submitted per transaction.
- Only one transaction should be submitted per functional group.
- Only one functional group should be submitted per interchange.
- If no date of service is received, the current date will be considered as the date of service.

8. Acknowledgments and/or reports

As the 270 transaction is designed to be exchanged for a 271 response containing the benefit information sought in the 270 request, Humana will not send any acknowledgment that the 270 has been received, unless there is a problem processing the request.

9. Trading partner agreements

This section contains general information concerning trading partner agreements (TPA).

Trading partners

An EDI trading partner is defined as any Humana customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits electronic data to or receives electronic data from Humana.

To ensure the integrity of the electronic transaction process, payers have EDI trading partner agreements that accompany the standard implementation guide. The trading partner agreement is related to the electronic exchange of information, whether the agreement is with an entity or part of a larger agreement. For example, a trading partner agreement may specify the roles and responsibilities of each party to the agreement in conducting standard transactions.

As Humana will be directly exchanging data only with Availity, the existing trading partner agreement between Humana and Availity will cover these transmissions. It may be necessary for those originating these transactions to complete similar documents with Availity. To complete the required documents, please review this document:

Availity® Health Information Network Batch Electronic Data Interchange (EDI) Standard Companion Guide: www.availity.com/documents/edi_guide.pdf

10. Transaction-specific information

The table below contains a row for each segment that is specific to Humana. Due to this specificity, this information is not included in the implementation guides.

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

Instruction tables

ISA

005010X279A1 Health Care Eligibility and Benefit Inquiry and Response

See Availity's companion guide for ISA requirements.

GS segment

005010X279A1 Health Care Eligibility and Benefit Inquiry and Response

See Availity's companion guide for GS requirements.

Functional group header

Humana requires the use of the Humana payer ID in GS02 and the application receiver code in GS03. The intent is to identify what type of data is being sent, how the trading partner received the data and if there is a fee to be paid for these transactions.

005010X279A1 — Health Care Eligibility and Benefit Inquiry (270)

Loop ID	Reference	Name	Codes	Notes/comments
Header	BHT	Header		Humana requirements
	BHT02	Transaction Set Purpose	13	Humana only accepts "13"
2100A	NM1	**Information Source**		Humana requirements
	NM101	Entity Identifier Code	PR	Used to identify the type of organization. Payer = Humana
	NM102	Entity Type Qualifier	2	Used to identify type of entity. 2 = Nonperson entity
	NM103	Organization Name	Humana	Organization name
	NM108	Identification Code Qualifier	PI	Payer identification
	NM109	Identification Code		Humana medical = 61101 Humana Long-Term Care = 61115 Humana dental = 65065 CompBenefits Dental = CX021
2100B	NM1	Information Receiver Name		
	NM101	Entity Identifier Code	1P, 2B, 36, 80, FA, GP, P5	Humana does not accept "PR."
	NM108	Identification Code Qualifier	XX	Humana requires NPI qualifiers for all providers, except those classified as "atypical."
	NM109	Identification Code		

	REF01	Reference Identification Qualifier	TJ	Federal taxpayer identification number
	REF02	Reference Identification		
2100C	NM1	**Subscriber Name**		For multiple births, please refer to the 2100D Loop.
	NM108	**Identification Code Qualifier**	MI	Humana only allows "MI" (member identification number).
	NM109	**Identification Code**		If the subscriber is a non-Medicaid member, the member ID (identification code) found on the Humana ID card is required. If the subscriber is a Medicaid member, the subscriber segment is required but NM109 is not required.
	REF01	**Reference Identification Qualifier**		If NM109 is blank in 2100C and the subscriber is a Medicaid member, then NQ is required.
	REF02	**Reference Identification**		The Medicaid member ID is required if NM109 in 2100C is blank.
	N4	**Subscriber City, State**		
	N401	**City Name**		Humana requires the city name for Medicaid members.
	N402	**State or Province Code**		Humana requires the state name for Medicaid members.
	DMG	**Subscriber Demographic Information**		
	DMG01	**Date Time Period Format Qualifier**	D8	Required by Humana
	DMG02	**Date Time Period**	Subscriber Birth Date	Required by Humana

	DTP	**Subscriber Date**		
2100D	NM1	**Dependent Name**	03	For multiple births, this segment is required by Humana.
	NM103	**Name Last**		For multiple births, the 2100D NM103 and NM104 must include the last and first name(s) of the dependent(s).
	NM104	**Name First**		For multiple births, the 2100D NM103 and NM104 must include the last and first name(s) of the dependent(s).
2110C	EQ	**Eligibility or Benefit Inquiry**		
	EQ01		1, 2, 3, 4, 5, 6, 7, 8, 12, 13, 18, 20, 30, 33, 35, 40, 42, 45, 47, 48, 50, 51, 52, 53, 62, 65, 68, 73, 76, 78, 80, 81, 82, 86, 88, 93, 98, 99, A0, A3, A6, A7, A8, AD, AE, AF, AG, AI, AL, BG, BH, MH, UC, 10	Humana supports all CORE-mandated service type codes.
	DTP	**Subscriber Eligibility/Benefit Date**		

005010X279A1 — Health Care Eligibility and Benefit Response (271)

The 271 response is exclusive to the payer ID that was received in the 270 request.

Loop ID	Reference	Name	Codes	Notes/comments
Loop 2100C	REF03	Description	Free-form	Used to indicate the plan, group or plan network name. This will vary by line of business. An example is: REF*6P*R7901001* HUMANA EMPLOYERS HEALTH PLAN OF GA,INC~
2100D	DTP01	Date/Time Qualifier	346 347	
	Humana Medical			
	Humana Dental			
	Humana Comp Benefits			

Humana requires the use of the member ID number shown on the Humana insurance card.

Example

NM1*IL*1*DOE*JOHN*T**JR*MI*123456789***~

HumanaOne

Billing scenario	EB01	DTP	2110C/D MSG
Member has not activated his/her coverage	7 (Inactive – Pending Eligibility Update)		Message: The member's first month's premium payment has not been received. This payment is required to activate their coverage. Members can go to www.humana.com/payinfo to learn how to make this payment.
Member has activated coverage and is current on bill payments		DTP01 = 343 (premium paid to end date)	

OnExchange/ APTC/Grace Period Month 1	5 (Active – Pending Investigation)	DPT01 = 193 for grace period start date and DTP01 = 194 for grace period end date	Message: Health Insurance Exchange Grace Period Month 1 Message: The member's most recent payment has not been received. Payment in full is necessary to maintain coverage. Members can go to www.humana.com/payinfo to learn how to make payment in full or pay via our automated payment line at 800-223-3659 24/7.
OnExchange/ APTC/Grace Period Month 2 or Month 3	5 (Active – Pending Investigation)	DPT01 = 193 for grace period start date and DTP01 = 194 for grace period end date	Message: Health Insurance Exchange Grace Period Month <x> (x = 2 or 3) Message: The member's most recent premium payment has not been received. Claims may pend, deny or a claim refund may be requested for services provided if premium is not paid. Members can go to www.humana.com/payinfo or pay via our payment line 24/7 at 800-223-3659.
When Humana is updating a member's account	5 (Active – Pending Investigation)		Message: We are updating this member's account. This does not mean the member has not made payment. Claims may pend, deny or a refund may be requested for services provided during an update. Members can go to www.humana.com/payinfo or pay via our payment line at 800-223-3659.

If a single-date inquiry is sent and an active plan is not found for the member, please submit a subsequent request with a different date. Humana does not employ logic to search for the future or previous active timeline for the member. Single-date inquiries of 24 months in the past up to the current month are acceptable.

1. For explicit or category 271 responses, an eligibility benefit (EB) data segment indicating active (1), inactive (6 – dental or V for medical) in loop 2110C/D EB01 will be returned for supported HIPAA service type codes.

   Inactive benefit example:
   EB*6**35~ = inactive dental coverage
   DTP*349*D8*20150630~ = coverage ended as of 6/30/2015

2. When applicable, an EB data segment in loop 2110C/D will be returned with benefit level copayments, coinsurance and deductible amounts. Remaining benefit deductible will be returned, if applicable.

Base deductible example for a benefit:
EB*C*IND*33****500*****Y~ = individual has a $500 base deductible for in-network chiropractic care

Remaining deductible example for a benefit:
EB*C*IND*33***29*183*****Y~ = individual has a $183 remaining deductible for in-network chiropractic care

3. When a benefit has multiple in-network copayments, coinsurance, deductibles, limitations or cost containment measures, a message segment will be sent distinguishing between multiple in-network benefits. The message segment will directly follow the EB data segment in loop 2110C/D to which the message applies.

   Highest in-network benefit coinsurance example:
   EB*A*IND*81***27**.20****Y~ = individual has a 20% coinsurance for in-network routine physical
   MSG* PlanMaximum
   or
   MSG*Pharmacy

4. The eligibility response will populate loop 2100C/D – EB03 valued with 30 – DTP01 with "346" to represent the health plan coverage start and end dates. When only one date is sent in the response, the date represents the member's eligibility start date; DTP02 will be valued with "D8". When DTP02 value of "RD8" is sent, then both a start date and end date will be sent, meaning coverage has ended.

Health plan coverage example:
DTP*346*D8*20070501~ = Member eligibility started on 05/01/2007

The remaining health plan (in loop 2110C/D EB03 = 30) deductible and out-of-pocket values will be returned in the 271.

Remaining deductible example:
EB*C*IND*30***29*266*****Y~ = Individual In-network Health plan remaining deductible is $266

A message specific to certain Humana plans will be returned in the message segments. Examples of specific messages are listed below:

Description	Message
Dual Eligible Special Needs Plans	Member is not responsible for medical copayments, medical coinsurance or medical deductibles for this Dual Eligible Special Needs Plan. Member is cost-share protected by the state Medicaid office while enrolled in this plan. Member cannot be balanced billed
Long Term Services & Support Waiver	Aged Waiver
Humana reconciling a HumanaOne member's account	We are updating this member's account. This does not mean the member has not made payment. Claims may pend, deny or a refund may be requested for services provided during an update. Members can go to www.humana.com/payinfo or pay via our payment line at 800-223-3659
HumanaOne Non Advanced Premium Tax Credit message	The member's most recent premium payment has not been received. Claims may pend, deny or a claim refund may be requested for services provided if premium is not paid. Members can go to www.humana.com/payinfo or pay via our payment line 24/7 at 800-223-3659.
HumanaOne message when debit day is scheduled	Member's premium payment for current month is scheduled. Claims may pend, deny, or a claim refund may be requested for services provided if premium is not paid
HumanaOne /Advanced Premium Tax Credit Grace Period Month Identifier	Health Insurance Exchange Grace Period Month 1
HumanaOne/AdvancedPremium Tax Credit Grace Period Month 1 Message	The member's most recent premium payment has not been received. Payment in full is necessary to maintain coverage. Members can go to www.humana.com/payinfo to learn how to make payment in full or pay via our automated payment line at 800-223-3659 24/7
HumanaOne/Advanced Premium Tax Credit Grace Period Month Identifier	Health Insurance Grace Period Month 2
HumanaOne/Advanced Premium Tax Credit Grace Period Month 2 Message	The member's most recent premium payment has not been received. Claims may pend, deny or a claim refund may be requested for services provided if premium is not paid. Members can go to www.humana.com/payinfo or pay via our payment line 24/7 at 800-223-3659
HumanaOne/Advanced Premium Tax Credit Grace Period Month Identifier	Health Insurance Grace Period Month 3
HumanaOne/Advanced Premium Tax Credit Grace Period Month 3 Message	The member's most recent premium payment has not been received. Claims may pend, deny or a claim refund may be requested for services provided if premium is not paid. Members can go to www.humana.com/payinfo or pay via our payment line 24/7 at 800-223-3659

HumanaOne message	The member's initial premium payment has not been received. This payment is necessary to activate coverage. Members can go to www.humana.com/payinfo to learn how to make this payment or pay via our automated payment line at 800-223-3659 24/7.
Puerto Rico	Services received outside the territorial limits of Puerto Rico, except emergency transportation and emergency services for member categories 100/110/230 (chip) are excluded.
271 Footer Message for other coverages	This is only an estimation of benefits, and all payments are subject to policy guidelines, medical necessity, and member eligibility at the time services are performed.

5. If a member is a dual-eligible member (covered by both Medicare and Medicaid), Humana will return both the Medicare and Medicaid benefits. With dual membership, the member ID is the same for Medicare and Medicaid. An example is below:

   NM1*IL*1*DOE*JOHN*M***MI*H00000000
   REF*6P*R8975001*HUMANA HEALTH PLAN, INC.
   EB*1*EMP*30*HN*076 843 HN
   MSG*MER RISK GATE CAP EXC
   MSG*Humana Gold Plus Integrated

   NM1*IL*1*DOE*JOHN*M***MI*H00000000
   REF*6P*R8962001*HUMANA HEALTH PLAN, INC.
   EB*1*EMP*30*MC*020 159
   MSG*MEDICAID GATE CAP DIR
   MSG*Humana Gold Plus Integrated

6. If a member has a telemedicine benefit, Humana will return a message segment indicating the benefit.

   EB*A**98*****.2****Y~
   MSG*Seq#002~
   MSG*TELEMEDICINE~

Eligibility and benefits response error codes

Message type	Message code	Loop	Reject message	Resolution
AAA	76	2100 C	Duplicate subscriber/insured ID number	Please provide patient first and last name to resolve the error.
AAA	41	2100 A	Authorization/access restrictions	If you receive this error, please call 1-800-457-4708 as this patient has applied for coverage but has not been approved by CMS and does not have coverage with Humana.

11. Other resources

ACS X12 TR3 implementation guides: http://store.x12.org