THE NEWEST CAPABILITIES THE FUTURE ELECTRONIC ELIGIBILITY & BENEFIT OFFER

DONNA CAMPBELL
PRODUCT MANAGER – PROVIDER PORTALS & CONNECTIVITY, HCSC

MAY 2024

DISCLAIMER

- This presentation is for informational purposes only
- This presentation is not intended to represent legal advice
- The content is point-in-time information and is subject to revision
- If you have questions regarding specific information, please send them to info@x12.org
- Visit www.x12.org for additional details about X12

The Future of the X12 270/271 A look-ahead

TODAY

- Speaking as an X12N (insurance) TGB (Task Group) WG1 Benefit Information workgroup member
- Not representing X12 nor my role within X12N/TGB/WG1
- Formal liaisons between X12 and WEDI who are on point for anything dealing with X12 & WEDI's exchange of information
- Discussion today will review only those changes that are included in the latest published version of the 270/271 – which is 8040
- **This review is not an all-inclusive catalog of the differences and should not be used as a replacement for organizations' independent reviews of the changes**

TODAY'S SCOPE

- A brief review of the new business capabilities that have been introduced in future versions of the 270/271 Eligibility & Benefit Inquiry and Response

  We will review and discuss at a high level the 270 Inquiry and 271 Response

  The review will focus on the business capabilities

  This review will not address the technical aspects of these changes, i.e., it will not dive into the details of the actual changes in the physical 270 or 271

TERMS AND DEFINITIONS

- To ensure consistency in terminology and meaning, X12 maintains a comprehensive corporate glossary called the Wordbook
- The Wordbook is available online at https://wordbook.x12.org/
- Reference the Wordbook if you have questions about any term in this presentation

ADVANCING THE VERSION OF TRANSACTIONS

- X12 has published three+ 270/271 versions since 5010, none of which were recommended for HIPAA adoption
- Changes are vetted within a workgroup that represents providers, payers, clearinghouses, vendors, and associations
- All changes have followed a prescribed and well-defined process
- Anyone can request changes to any TR3
  - *To submit a maintenance request, visit x12.org/resources/forms/maintenance-requests, referencing the instructions.*

GENERAL INFORMATION

- The 270/271 ”front matter” has a lot of important information. It provides requirements and guidance for different business scenarios. The requirements and guidance will vary depending on the type of parties exchanging the 270/271, for what line of business, and what purpose
- It’s CRITICAL that each organization review the changes between 005010 and any new version independent of this overview of the changes to ensure completeness

GENERAL INFORMATION

- The terms ‘Information Receiver,” ‘Information Source’ and “Member” are commonly used within the TR3
  - *The term “provider” is heavily used in this presentation; in practice, ”provider” may be interchangeable with “information receiver”*
  - *The term “payer” is heavily used in this presentation; in practice, ”payer” may be interchangeable with “information source”*
  - *The term “member” is heavily used in this presentation; in practice, “member” may be interchangeable with ”patient”, “subscriber”, or “dependent” depending on context*

GENERAL INFORMATION

- Front matter sections have added and modified scope:
  - *ePrescribing Requirements – ePrescribing companion guide embedded within the front matter to provide the pharmacy industry expectations within one document*
    - WG1 worked with pharmacy benefit vendors and NCPDP
    - Set of requirements only apply to the pharmacy/prescription drug line of business
  - *Dental Industry Usage – introduced guidance in front matter for use of the 270/271 within the dental community; these changes also introduced new dental changes to the 270 and 271*

WHAT'S CHANGED ON 270 INQUIRY?

- 270 Inquiry will offer support for:
  - ***Former Name*** *- the information receiver (often the provider) will have the ability to send a former name for a member on the 270. The information source (often the payer) may use this information in member matching, or for other needed uses defined by the payer*
  - ***Rendering Provider*** *– the information receiver*
  - ***Benefit and Cost Shares by network level*** *–i.e., In Network, Out of Network*
- Payers are required to support multiple service type code requests on a single 270

WHAT'S CHANGED ON 270 INQUIRY?

→ 270 Inquiry will offer support for:

- *Dental support has been added specifically to include identification of tooth/teeth and tooth surfaces*
- *New dental-specific service type codes that cover more appropriately the dental environment*
- *Date of service support and date range support – providers will now receive eligibility, coverage and benefit responses that will be specific to the dates outlined on the providers' 270 request*

WHAT'S CHANGED ON 271 RESPONSE?

→ The following slides provide an overview of significantly important changes:

- *Cascading Search Logic – Searching and Matching for a member*

  Outlined a set of steps to follow, in no prescribed order, requiring payers to follow the different types of search and match combinations (when all 4 pieces of member identifying information are sent on a 270 Inquiry)

  Supports the same Primary Search and Required Alternate Search combinations that are used in 5010 today

  Does not include ACA Operating Rule's Name Normalization requirements

WHAT'S CHANGED ON 271 RESPONSE?

→ Service type codes value-add changes are included in this review

- *Service Type Code 30 and 60 re-definition*
- *Addition of Service Type Code Descriptors*
- *Service type codes have been 'revamped' for better alignment to the industry's current and near future health care needs*
- *Each of these have been moved to be external code lists and are managed outside of the workgroup*

The benefit of these being made external: the service type codes can be added, thus used with the 270/271 much quicker without reliance on a standard or TR3 version update. These codes are managed outside WG1. You can view these codes now from https://x12.org/codes

WHAT'S CHANGED ON 271 RESPONSE?

Service Type Code Changes

- *Service Type Code 30 and 60 re-definition - Moved away from the confusing descriptions and made them more aligned with what the industry felt they more appropriately represented*
- *Addition of Service Type Code Descriptors – Descriptor codes behave similarly (not exactly) to how modifiers apply to procedure codes. They're an extension of the service type codes to help separate where there are slight nuances e.g., X-Ray, MRI/CT Scan – Professional/Technical, Physician Visit-Sick—Specialist*
- *Require explicit support for all health care service type codes within the context of the payers' plans/policy and benefit offerings*

WHAT'S CHANGED ON 271 RESPONSE?

Service Type Code Changes

- *Service Type Code to describe Plan types have been added to the external service type code list*
- *These plan types have a number of benefits to the 271, namely streamlining the benefit response to be 'grouped' by plan type:*

  A payer can now send service type codes that ***could*** have been duplicative and confusing to a provider and align them with the payer's product(s) and lines of business

  I.e., X-Ray is as service/benefit that can be offered with a dental plan, a medical plan, and a vision plan. With the new plan type codes, you can return X-ray within the context of the plan type it's associated with to make clear the differentials between them

  - X-ray for dental – 1 set covered 1x a year
  - X-ray for medical – no limit
  - X-ray for vision – 1 set covered 2x a year

WHAT'S CHANGED ON 271 RESPONSE?

Benefit related changes

- *Added requirements to mirror Operating Rules, e.g., base and remaining cost shares*
- *A new way to show a cost share is 'shared' across several service types or plan types has been introduced*

  e.g., visit limitations apply to a ***set*** of services

- *Message segment uses and restrictions are introduced*
- *Tiered Benefits – ability to identify a tier and its tier description to differentiate between levels of benefits related to the provider network and member's benefit contract*

WHAT'S CHANGED ON 271 RESPONSE?

Prior Authorization Requirement support

- *Introduced a new way to provide types of service or procedure prior authorizations required by the payer*

  This allows for all of the types of required prior authorizations to be returned, such as specialist referrals, and authorizations for a given place of service for a service to be performed

  Timely, needed, yet simple business enhancement in light of the heightened prior authorization interoperability efforts that have recently been introduced

WHAT'S CHANGED ON 271 RESPONSE?

Date support changes

- *A payer must support eligibility and benefit inquiries as far back as 18 months or their timely filing limits allow*

  This will help providers who file claims based on episodes of care well into the treatment journey to file claims with some assurance that the information that's required for a claim is available via the eligibility and benefit response for the payers' filing requirements

  - Helps reduce claim front end denials based on absent or incorrect data on the claim
  - Helps ensure the provider's data matches the payer's data to alleviate a delay in claims processing
  - Helps revenue cycle delays by allowing a look back eligibility period

WHAT'S CHANGED ON 271 RESPONSE?

Error handling changes

- *A new way to return errors has been designed for use in the 271 Response*
- *No longer referred to as Reject Reason Codes; Referred to as Error Reason Codes*
- *Is also externally maintained; can be found in the same location as the service type codes and service type descriptors*
- *Allows a payer to return a way to specify if the error is 'catastrophic' in nature, thereby indicating that some or all of the required response data may not have been returned because of the type and severity of the error(s)*

WHAT'S CHANGED ON 271 RESPONSE?

Error handling changes

- *Non-catastrophic errors are essentially treated as informative*
- *Non-catastrophic errors and eligibility, coverage and benefit information are allowed to be returned together in the same response*

  Today, in most cases, if any reject reason code is returned, eligibility, coverage or benefit details may be prohibited from being returned

  The new change allows the payer to pass to the provider some needed information that may be available even in the event where certain non-severe errors are encountered and present

WHAT'S CHANGED ON 271 RESPONSE?

Error handling changes

- *Non-catastrophic errors and eligibility, coverage and benefit information are allowed to be returned together in the same response*

  e.g., Provider may have sent a middle **initial** for a member; while the middle name wasn't 'validated' in the matching, it was observed to be different than what was on the payer's system. It didn't negate the payer's ability to return eligibility, coverage or benefits so the payer may still return all that's required to meet the implementation guide requirements but also return that the middle initial on the 270 did not match the middle **name** that was in the payer's system

WHAT'S CHANGED ON 271 RESPONSE?

Error handling changes

- *Critical errors, depending on location, would restrict the return of eligibility, coverage or benefit details. This is dependent on the type of data that caused critical error*

  e.g., Provider may have sent an ID, last name and a date of birth for a member; while validating the ID, last name and date of birth, it was found that the ID did not match anyone on the payer's system with the last name or date of birth. This error would be 'critical' in that there'd be no way any eligibility, coverage or benefit details could be returned if there was no match to a member in the payer's system

A NEW BEST FRIEND TO THE TR3

Type 2 Technical Report

- *Some of the front matter in 5010X279A1 listed requirements identifying what must be returned in certain scenarios, such as when an information source received a Health Benefit Plan Coverage (now called Plan Coverage and General Benefits) service type code. Response requirements were defined in the front matter.*
- *As a result of the service type codes moving externally, offering a more frequent update process for codes to be added for use within the 270/271 as the industry identifies the need, the requirements that outline what must be returned haver been moved to a separate, still formally-defined document, referred to as a Type 2 Technical Report (TR2)*

A NEW BEST FRIEND TO THE TR3

Type 2 Technical Report

- *The TR2 will now be maintained as a separate but equally important artifact to the TR3, allowing changes to what is required to be returned in the 271 based on a prescribed timeline, also driven by the maintenance request process, but outside of Standard maintenance*
- *The TR2 also includes some basic guidance and historical information for service type descriptor, error reason code handling information, and outlines information regarding the grouping capability for eligibility and benefits by plan type, date, etc.*

WRAP-UP

SUMMARY

- A lot of information was presented today
- Not all will apply to everyone on this call
- This information was provided from the context of a WG1 participant and member, not that of a formal X12 role
- This is a subjective opinion, short list of the most highly valuable changes incorporated to date
- Additional changes will be made as more maintenance requests are processed

COME JOIN ME AT X12N/TGB WG1

- Standing Meeting in Jacksonville, Florida
- June 3 - 6 2024
- Registration is open through May 24, 2024

- Standing Meeting in Pittsburgh, PA
- September 14-29, 2024
- Watch for registration to open in July/August

x12.org/news-and-events/meetings

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