
Wellmark Blue Cross and Blue Shield

HIPAA Transaction
Standard Companion Guide
Section 2, 270-271 Eligibility and Benefits
Refers to the X12N Implementation Guide
ANSI Version 4010A1

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Version 3.0

This *Companion Guide* is a work in progress. Wellmark reserves the right to make changes to this *Companion Guide* at any time without notice. Changes appear in blue text and may be accompanied by a yellow note in the margin.

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1 Introduction

Wellmark places a high priority on making it easy for you to do business with us. Using an electronic medium to make an inquiry is one of the ways we can do this. Electronic inquiries facilitate the transfer of information from your organization to ours in a standard data format. This Section 2 of the *Wellmark Companion Guide* provides information about the American National Standards Institute (ANSI) Health Care Eligibility Benefit Inquiry and Response 270-271 transaction, Version 4010A1A. This transaction is the accepted standard of the 1996 Health Insurance Portability and Accountability Act—Administrative Simplification. (HIPAA-AS).

The *Wellmark Companion Guide* is to be used alongside the *HIPAA-AS Implementation Guide (IG)*, which provides comprehensive information needed to create an ANSI 270 transaction and details the information returned in the ANSI 271 transaction. The *Wellmark Companion Guide* does not change the specifications of the *HIPAA Implementation Guide*; rather, it is intended to clarify the areas where the IG provides options or choices to be made. The *HIPAA-AS Implementation Guide* can be downloaded from http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

When you send a transaction to Wellmark, it will go through EC Solutions Interactive Network (INet) facility first. The INet translates the ANSI 270 standard transaction into a format readable by our internal systems. Section 1 of the *Wellmark Companion Guide* provides further information about the process of sending electronic transactions to Wellmark via EC Solutions.

Implementation Considerations

The 270/271 electronic batch transaction works best for employers or healthcare practitioners and facilities with the capability of posting this information to an employee or patient account record. However, it may not be as user-friendly for individual transactions or as convenient as our current web tools for Eligibility Verification and Benefit Inquiry. (See the Group or Provider sections at Wellmark.com for information on these services.)

For 271 responses, Wellmark will create Eligibility and Benefits (EB) loops to share deductible, coinsurance, copayments, out-of-pocket maximums and lifetime limits. These loops may include text in MSG (message) segments that explain additional provisions and limitations that apply to a given benefit. The amount of information will vary from product to product for different patients. Like our web transactions, these are available for all lines of Blue Cross and Blue Shield business.

Wellmark will not, at this time, respond to requests regarding coverage for specific benefits and treatment procedures. Rather, each response will include general enrollment and benefits data as identified in the paragraph above.

The web tool for Eligibility and Benefits is HIPAA compliant in content. The benefit values available today that are not represented in a standard 271 transaction will continue to be accessible via separate links in the web tool.

For Providers of Health Services Only:

For business done through the traditional BlueCard[®] program, providers of health services can access on-line information on eligibility and benefits by using the three-digit alpha prefix when searching for a member with coverage in another Plan. The revised web tool will enable an office that cannot create batch transactions to make a request for eligibility and benefits by using the out of state prefix with a request on the web page.

For BlueCard® members, you will need to complete additional fields so Wellmark can create a 270 request on your behalf and forward to the other Blue Plan for a response. Your reply will be displayed on the web page.

Please remember that Wellmark has no control over the amount of information in the replies received from other Blue Plans. The content of those replies will likely be different from the information offered by Wellmark. A compliant response could range from a simple “yes/no” indicating that the patient has a medical contract, to a detailed list of covered services.

What follows is a matrix of the values important when completing a successful 270 Eligibility and Benefit inquiry transaction. As with other HIPAA-AS transactions, you should test the process for generating and submitting valid requests, and receiving 271 transaction responses. You will want to work with your vendor or clearinghouse to perform the appropriate testing.

Special notes:

- Please note the Wellmark 270 transaction requirements specified in the matrix for the NM1 segment of the Information Receiver loop. This segment must contain either a Federal Tax ID or a provider NPI that is found on Wellmark’s provider file, in order to receive a 271 response containing enrollment and benefit information for a patient. If an inquiry (270 transaction) does not contain one of these values, Wellmark will respond with a 271 transaction that contains a Request Validation (AAA) segment at the Information Receiver Level with Yes/No Condition (AAA01) = Y, and Reject Reason Code (AAA03) = 50 (provider ineligible for inquiries).
 - Wellmark requires that the following field elements be populated in the 270 request, in order to positively identify the patient’s eligibility and enrollment data and return a 271 response:
 - Patient’s Member ID number, including the alpha prefix
 - Patient’s First Name
 - Patient’s Last Name
 - Patient’s Date of Birth
 - If a single 270 transaction contains requests regarding more than one patient, Wellmark will internally process the requests one-at-a-time, and will generate a separate 271 response transaction for each patient. Providers should plan to utilize the trace (TRN) segments available at the Subscriber and Dependent loops when matching the 271 response(s) from Wellmark to their original 270 request transactions.
- * For members of the Federal Employee Program (FEP), the “R” at the beginning of the employee ID number constitutes the “alpha prefix”.

Matrix for the 270/271 Inquiry and Response

LEGEND

SHADED rows represent “segments”; **NON-SHADED** rows represent “data elements.”

“Loop – specific” comments are found in the first segment of the loop.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
44	2100A	NM1	Information Source Name			
46		NM108	Identification Code Qualifier	PI		
46		NM109	Identification Code	88848		Wellmark Blue Cross and Blue Shield
50	2100B	NM1	Information Receiver Name			
52		NM108	Identification Code Qualifier	XX		
52		NM109	Identification Code		10	National Provider Identifier (NPI) as assigned by NPPES
71	2100C	NM	Subscriber Name			
72		NM103	Name Last or Organization Name		35	Be sure to use the policyholder's name as it appears on the Wellmark ID card.
72		NM104	Name First		25	
73		NM108	Identification Code Qualifier	MI	2	
73		NM109	Identification Code		4-17	The policyholder identification on the member's card, <i>including the prefix</i> , is required to determine which Blue Plan will respond to the inquiry.
83	2100C	DMG	Subscriber Demographic Information			
84		DMG01	Date Time Period Qualifier	D8	2	
84		DMG02	Date Time Period	CCYYMMDD	8	Use when the subscriber is the patient.

89	2110C	EQ	Subscriber Eligibility or Benefit Inquiry Information			
90		EQ01	Service Type Code	30	2	Wellmark does not support the remaining codes. However, the remaining EQ codes may be used in transactions for patients in other Blue Plan areas.
114	2100D	NM	Dependent Name			
115		NM103	Name Last or Organization Name		35	Used for the dependent's name when the dependent is the patient.
115		NM104	Name First		25	Used for the dependent's name when the dependent is the patient.
116		NM108	Identification Code Qualifier	MI	2	
116		NM109	Identification Code		15	The policyholder identification on the member's card, <i>including the prefix</i> , is required for all transactions.
124	2100D	DMG	Dependent Demographic Information			
125		DMG01	Date Time Period Qualifier	D8	3	
125		DMG02	Date Time Period for the policyholder's date of birth.	CCYYMMDD	8	Use when the dependent is the patient.
131	2110D	EQ	Dependent Eligibility or Benefit Inquiry Information			
132		EQ01	Service Type Code	30	2	Wellmark does not support the remaining codes. However, the remaining EQ codes may be used with transactions for patients in other Blue Plan areas.