



UnitedHealthcare Pre-Release Notice MN AUC Eligibility

Minnesota has passed legislation that requires changes to UnitedHealthcare's 270/271 transaction. The Commissioner of Health developed this rule in consultation with the Minnesota Administrative Uniformity Committee (AUC) and its Eligibility Companion Guide Work Group. To obtain information about this legislation, go to the Minnesota Department of Health Web site at <http://www.health.state.mn.us/asa/rules.html>; where you can access the MN Uniform Companion Guide for the 270/271. An additional resource for the MN Uniform Companion Guide for the 270/271 is at <http://www.health.state.mn.us/asa/mn270271guide.pdf>.

While the legislation was passed by Minnesota, *UnitedHealthcare has determined that it will be making these changes for all business, not just business in Minnesota.* The changes will apply to most commercial and government business (Payer ID's – 87726 and 94265) that is serviced by either UnitedHealthcareOnline.com, or its B2B options including Connectivity Director and B2B Gateway.

UnitedHealthcare's Companion Guide for the 270/271 eligibility transaction is currently being updated and will be available for distribution in mid-November, 2008. Interested parties will be able to access the guide at http://www.uniprise.com/hipaa/companion_docs.html, or via UnitedHealthcareOnline.com → News.

Below is a summary of the changes that will be made to the 270/271 in December 2008.

270 Request

1. Eligibility requests for any explicit service type code (EB03) request will now generate a 271 response. The 271 response will be the same as if a generic service type code "30" (Health Benefit Plan Coverage) 270 request came in.
2. The search logic will be changed to use a combination of the following data elements: Member ID, Last Name, First Name and Patient Date of Birth (DOB). Values for each one of these data elements are not required. The cascading search logic will go through the criteria supplied and attempt to find a match. If a match is not found or multiple matches are found, a 271 response will be sent indicating to the user what criteria needs to be supplied to find a match. For more details please refer to the MN Eligibility Companion Guide.

The following table describes the data received for each search scenario that will be supported.

SCENARIO	Patient/Member ID	Last Name	First Name	Patient DOB
1	x	x	x	x
2	x	x		x
3	x		x	x
4	x			x
5	x	x	x	
6		x	x	x

271 Response

Loop 2110C/D

3. The following HIPAA service type codes (2110C/D EB03) may be reported in the 271 response:

EB03 value	Description
1	Medical Care
30	Health Benefit Plan Coverage
33	Chiropractic

35	Dental Care
47	Hospital
48	Hospital – Inpatient
50	Hospital – Outpatient
52	Hospital Emergency Medical (Emergency Room)
68	Well Baby Care
81	Routine Physical
86	Emergency Services (Urgent Care)
88	Pharmacy
91	Brand Name Prescription Drug
92	Generic Prescription Drug
96	Professional (Physician)
98	Primary Care Physician
98	Professional Physician Visit - Office
A4	Psychiatric (Mental Health)
AL	Vision (optometry)
A6	Psychotherapy
A7	Psychiatric - Inpatient
A8	Psychiatric - Outpatient
AE	Physical Medicine

4. An eligibility benefit (EB) data segment indicating active (1), inactive (6) or non-covered (I) in loop 2110C/D EB01 will be returned for supported HIPAA service type codes in the 271 response to.

Active Benefit Example:

EB*1**88 = active coverage for individual in-network pharmacy benefits

Inactive Benefit Example:

EB*6**35 = inactive dental coverage

DTP*349*D8*20080630 = coverage ended on of 6/30/2008

Non-covered Benefit Example:

EB*1**96 = Specialist is not covered:

5. When applicable an EB data segment in loop 2110C/D will be returned with benefit level co-payments, coinsurance and base deductible amounts.

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

6. When a benefit has multiple in-network co-payments, 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 loop 2110C/D and EB data element that the message segment applies to.

Highest in-network benefit coinsurance example:

EB*A*IND*81***27**20****Y~ = individual has a 20% coinsurance for in-network routine physical
MSG* HIGHEST BENEFIT = highest benefit level for in-network benefits

7. The eligibility response will populate loop 2100C/D – EB03 valued with 30 - DTP01 with '307' 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. Prior to these changes UnitedHealthcare sent '356' for eligibility begin and '357' for eligibility end.

Health plan coverage example:

DTP*307*D8*20070501 = Member eligibility started on 05/01/2007

8. Insurance type code when available will be returned in loop 2100C/D - EB04 data element in the health plan coverage, cost containment and out-of-pocket EB data segments.

Insurance type code example:

EB*1**C1*Choice Plus = Member has active coverage under a commercial plan – Choice Plus

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

Remaining deductible example:

EB*C*IND*30***29*266****Y = Individual In-network health plan remaining deductible is \$266

10. When UnitedHealthcare knows of additional payers and knows the name of the other payer, the other payer name will be sent in the 2110C/D loop with EB01 valued with 'R'. In the 2120C/D loop a NM1 data segment will be included to identify the other payer name.

Additional payer example:

EB*R**30~ = Additional payer exists

LS*2120~ = Loop identifier start

NM1*PR*2*MEDICARE~ = Non-person payer name is Medicare

LE*2120 = Loop identifier end

11. An EB data segment in loop 2110C/D will be included in the 271 response for any limitations that apply to a benefit.

Limitation dollar example:

EB*F*IND*33***23*500****Y = Individual in-network chiropractor benefits are limited to \$500 per calendar year

Limitation visit example:

EB*F*IND*33***25**VS*5**Y = Individual in-network chiropractor benefits are limited to 5 visits per contract (policy) year

Limitation visit example with Health Care Services Delivery (HSD) data segment:

EB*F*IND*96*****Y~ = Limitation for individual in-network Professional (Physician)

HSD*VS*5***34*6 = limitation period is 5 visits in 6 months

Limitation dollar example with HSD segment:

EB*F*IND*33***500****Y~ = \$500 limitation for individual in-network chiropractor benefits

HSD***34*6 = Limitation period is 6 months

Additional covered dollar per occurrence/day limitation example:

EB*F*IND*48***20****Y~ = \$20 limitation for individual in-network hospital-inpatient.

MSG*Additional Covered per Occurrence = Additional covered dollars per occurrence/day which identifies the additional dollar allowance over the semi-private rate. Allow the semi-private room rate plus \$20.00.

12. An EB data segment in loop 2110C/D will be included in the 271 response for any cost containment measures that apply to a benefit. Cost containment is defined as a penalty that impacts a member's financial responsibility for member non-authorization.

Cost Containment example:

EB*J*IND*A7*C1*****Y*Y

MSG*Prior authorization is required otherwise member's financial responsibility will not be at the network level

13. An EB data segment in loop 2110C/D with the vendor's name will be included in the 271 response when a benefit is administered by another vendor.

Vendor name example:

EB*U**35~ = Contact following vendor for dental benefits

LS*2120~ = Loop identifier start

NM1*VN*2*ABC Dental~ = Non-Person vendor name is ABC Dental

LE*2120 = Loop identifier end

14. In loop 2110C/D a date or time or period (DTP) data segment will be included within the EB segment when the benefits' begin or end date is different than the health plans' begin or end date.

Benefit end date example:

EB*6**35~ = Dental coverage is in-active

DTP*349*D8*20080630 = Benefit coverage ends on 6/30/2008

15. If the patient is sent in the 270 2100D dependent loop, but UnitedHealthcare determines the patient is the subscriber, the 271 response will include the patient in the subscriber 2100C loop. If a TRN segment was submitted in the 270 2000D Loop, it will be returned in the 271 2000C Loop.
16. If the patient is sent in the 270 2100C subscriber loop, but UnitedHealthcare determines the patient is a dependent, the 271 response will include the patient in dependent 2100D loop. If a TRN segment was submitted in the 270 2000C Loop, it will be returned in the 271 2000D Loop.
17. Only the following HIPAA error codes will be used when a subscriber (2100C loop) is not found:
- 58 – Invalid/Missing Date of Birth
 - 64 – Invalid/Missing Patient ID
 - 65 – Invalid/Missing Patient Name
 - 67 – Patient Not Found
 - 71 – Patient Birth Date Does Not Match That for the Patient on the database
 - 72 – Invalid/Missing Subscriber/Insured ID
 - 73 – Invalid/Missing Subscriber/Insured Name
 - 75 – Subscriber/Insured Not Found

Example:

AAA*Y**72*C = Valid request using an invalid/missing subscriber ID, change/add subscriber ID and resubmit.

18. Only the following HIPAA error codes will be used when a dependent (2100D loop) is not found:
- 58 – Invalid/Missing Date of Birth
 - 64 – Invalid/Missing Patient ID
 - 65 – Invalid/Missing Patient Name
 - 67 – Patient Not Found
 - 71 – Patient Birth Date Does Not Match That for the Patient on the database

Example:

AAA*Y**64*C= Valid request using an invalid/missing patient ID, change/add patient ID and resubmit.