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HIPAA Eligibility Transaction System (HETS)
Health Care Eligibility Benefit Inquiry and Response (270/271)
5010 Companion Guide

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Disclosure Statement

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Provider Medicare beneficiary eligibility transaction is to be used for conducting Medicare business only.

The 271 response returned by the HETS 270/271 application 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.

Preface

This *Companion Guide* to the ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response and the ASC X12C/005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3 (TR3), adopted under HIPAA, clarifies and specifies the data content when exchanging Medicare beneficiary eligibility data electronically with CMS utilizing the HIPAA Eligibility Transaction System (HETS) 270/271 application. Transmissions based on this *Companion Guide*, used in tandem with the previously referenced TR3s, are compliant with both X12 syntax and the TR3.

This *Companion Guide* is intended to convey information that is within the framework of the TR3s adopted for use under HIPAA. This *Companion Guide* is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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1 Introduction

1.1 Scope

This document defines the Medicare eligibility request sent from Medicare-authorized Trading Partners and the corresponding response from the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) 270/271 application. To implement the HIPAA administrative simplification provisions, the 270/271 transaction set has been named under 45 CFR 162 as the Electronic Data Interchange (EDI) standard for Health Care Eligibility Benefit Inquiry/Response.

The HETS 270/271 application supports the ASC X12 270/271 version 005010X279A1 and the ASC X12 999 version 005010X231A1 TR3s that can be obtained via the following web site: https://x12.org/products/licensing-program. The 270 request and the 271 response are "paired" transactions. The 270 is an inbound eligibility request whereas the 271 is an outbound eligibility response.

This *Companion Guide* has two purposes. The first purpose is to educate the user on how to access the HETS 270/271 application. The second purpose is to educate the user on how to send eligibility requests and interpret responses, using the 270/271 formats, as they relate to the applicable Medicare required business rules and information.

1.2 Application Overview

The HETS 270/271 application provides access to Medicare beneficiary eligibility data in a real-time environment. Providers, Clearinghouses, and/or Third Party Vendors, herein referred to as “Trading Partners,” may initiate a real-time 270 eligibility request to query coverage information from Medicare on patients for whom services are scheduled or have already been delivered. In real-time mode, the Trading Partner transmits a 270 request and remains connected while the receiver processes the transaction and returns a 271 response.

The HETS 270/271 application is virtually located at a secure U.S. government high availability environment. To transmit data with CMS, Trading Partners may connect to the HETS 270/271 application via the CMS Extranet, which is a secure closed private network, or via the internet using a digital certificate. Trading Partners must not send User IDs and passwords within the 270 eligibility transaction.

For a real-time 270 request, the HETS 270/271 application translates the incoming 270 request, performs validations, requests Medicare beneficiary eligibility data from the CMS eligibility database, and creates either an Eligibility Response (271), an Implementation Acknowledgement (999), an Interchange Acknowledgement (TA1), or a proprietary error response.

The information included in the 271 response is not intended to provide a complete representation of all benefits, but rather to address the status of eligibility (active or

inactive) and patient financial responsibility for Medicare Part A and Part B. Additionally, the 271 response returned by the HETS 270/271 application should not be interpreted as a guarantee of payment.

The data included in a 271 response file is to be considered true and accurate only at the particular time of the transaction. Questions regarding eligibility/benefit data for Medicare Part A and Part B should be directed to the appropriate regional Medicare Administrative Contractor (MAC). Eligibility/benefit questions about Medicare Advantage (MA), Part D, and Medicare Secondary Payer (MSP) should be directed to the appropriate plan(s) identified in the 271 response. Eligibility/benefit questions about Qualified Medicare Beneficiary (QMB) eligibility should be directed to the State online Medicaid eligibility systems or other documentation, including Medicaid Identification cards and documents issued by the State proving the patient qualifies for the QMB program.

1.3 References

The ASC X12 TR3s that detail the full requirements for these transactions can be obtained from the publisher, Washington Publishing Company (WPC) at their website https://x12.org/products/licensing-program.

The HETS Trading Partner Agreement Form (TPA) to request access to the HETS 270/271 application is available for download from the CMS HETS Help website. Use the following link to display the “How to Get Connected – HETS 270/271” page and to access the TPA: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html.

For more information on the Web Services Communication Protocol Specifications for connecting to the HETS 270/271 application, refer to the HETS Trading Partner SOAP/MIME Connectivity Instructions available online here: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271SOAPMIMEConnectivity.pdf.

1.4 Additional Information

CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and HIPAA.

CMS implemented the HETS 270/271 application following a real-time request/response model (single response per request). The data available in this implementation allows a Provider to verify an individual’s Medicare eligibility and benefits. Medicare eligibility data is only to be used for the business of Medicare, such as preparing an accurate Medicare claim or determining eligibility for specific services. The HETS 270/271 application is not a Medicare claims processing or appeals system. Providers’ authorized staff members are expected to use and disclose protected health information according to the CMS regulations.

CMS monitors Medicare beneficiary eligibility inquiries. Trading Partners identified as having aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquiries to claims submitted, an excessive number of resubmissions of the same eligibility request in a single day, requesting psychiatric data when the NPI is not a Psychiatric provider) may be contacted to verify and/or address improper use of the system or, when appropriate, be referred for investigation.

1.4.1 Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information

In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include to:

- Verify eligibility, after screening the patient to determine Medicare eligibility, for Part A and/or Part B coverage
- Determine Medicare beneficiary payment responsibility with regard to deductible/copayment
- Determine eligibility for other services, such as preventive
- Determine if Medicare is the primary or secondary payer
- Determine if the Medicare beneficiary is in the original Medicare plan, MA plan or Part D plan
- Determine proper billing

1.4.2 Unauthorized Purposes for Requesting Medicare Beneficiary Eligibility Information

The following is an example of an unauthorized purpose for requesting Medicare beneficiary eligibility information:

- To determine eligibility for Medicare without first screening the patient to determine if they are Medicare eligible

1.4.3 Note to Medicare Providers/Suppliers:

The Medicare beneficiary should be the first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance coverage. This will not only help you determine who to bill for services rendered, but also give you the proper spelling of the Medicare beneficiary's first and last name and identify their MBI as reflected on the Medicare Health Insurance card. If the Medicare beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encourage them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-833-4455 to request a replacement Medicare Health Insurance card from RRB.

It is assumed that the reader of this document is familiar with the ASC X12 270/271 version 005010X279A1 and ASC X12 999 version 005010X231 TR3s and the transaction format and content rules contained within them. This *Companion Guide* is intended to be a complement to the ASC X12 270/271 and 999 TR3 versions noted above and not the sole authoritative source of data.

2 Getting Started

2.1 Working with the CMS Help Desk

The Medicare Customer Assistance Regarding Eligibility (MCARE) Help Desk is available to assist with this process Monday – Friday, from 7:00 AM to 7:00 PM ET. The MCARE Help Desk is closed on Federal holidays. MCARE is the single point of contact for all questions or concerns about the HETS 270/271 application. A potential Trading Partner must contact MCARE to initiate the registration process.

Please refer to Section 5 of this *Companion Guide* for MCARE contact information.

2.2 Trading Partner Registration

Entities must apply for and be granted access as an authorized Trading Partner before they will be able to utilize the HETS 270/271 application. Entities must complete an application via the HETS Trading Partner Agreement located at the following link: http://cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS_Trading_Partner_Agreement_Form.pdf

Instructions to complete the sign-up process can be found at the following link: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html

2.3 Certification and Testing Overview

Trading Partners are required to submit test transactions to ensure that their systems are X12 compliant. Each Trading Partner may submit up to 50 test transactions during the testing phase. Trading Partners must contact MCARE to coordinate testing procedures.

Please refer to Section 5 of this *Companion Guide* for MCARE contact information.

3 Testing

CMS requires that all newly registered Trading Partners work with MCARE to complete basic transaction submission testing. Successful transaction submission and receipt of both valid and error responses is an indication to CMS that all systems involved can properly submit and receive transactions. MCARE is available to assist with new Trading Partner testing Monday – Friday, from 9:00 AM to 5:00 PM ET. The MCARE Help Desk is closed on Federal holidays.

Trading Partners must send all test transactions with Usage Indicator (ISA15) = “T” until approved to submit production transactions with a Usage Indicator (ISA15) = “P.” The HETS 270/271 application will return a TA105 = “020” error for an Invalid Test Indicator Value if the incorrect value is included within this field.

Please refer to Section 5 of this *Companion Guide* for MCARE contact information.

4 Connectivity/Communications

4.1 Process Flows

4.1.1 Trading Partner Registration

To access the HETS 270/271 application, potential Trading Partners need to obtain a Submitter ID through MCARE. **Figure 1** illustrates the high-level process for successfully registering as a Trading Partner and submitting 270 transactions. Trading Partners are also required to recertify their HETS 270/271 application access annually by completing the Trading Partner Agreement (TPA) recertification process as instructed by CMS.

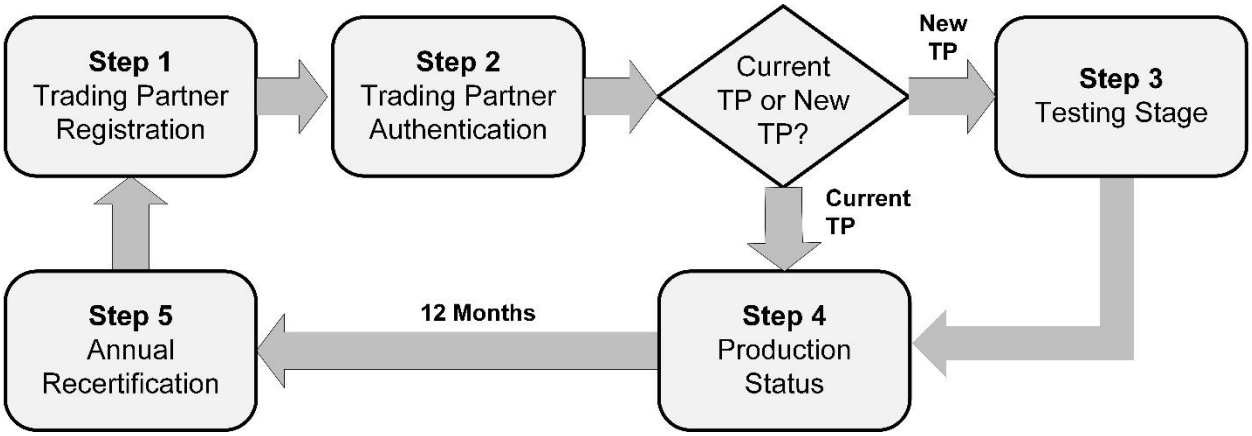

Figure 1. Process for Implementing 270 Transactions

Step 1: Trading Partner Registration
Complete and submit the HETS Trading Partner Agreement Form. Refer to Section 2.2 of this *Companion Guide* for the Trading Partner registration process.

Step 2: Trading Partner Authentication
MCARE will verify the information on the Trading Partner Agreement Form and approve or deny any Submitter ID requests.

Step 3: Testing Stage
MCARE will have a Trading Partner send up to 50 test transactions and verify that all systems involved can properly submit and receive X12 compliant transactions. The Usage Indicator (ISA15) must be “T.”

Step 4: Production Status
Once testing is complete, a Trading Partner can begin to submit 270 transactions and receive 271 transactions in the Production environment. The Usage Indicator (ISA15) must be “P.”

Step 5: Annual Recertification

Trading Partners that are in Production Status are required to recertify their access annually at a date predetermined by CMS. Trading Partners must complete an updated HETS Trading Partner Agreement and submit it per CMS' instructions. The updated Trading Partner Agreement is validated to ensure it remains compliant with CMS policy.

4.1.2 Transaction Process

A Trading Partner may submit a 270 request to the HETS 270/271 application using Transmission Control Protocol/Internet Protocol (TCP/IP), Simple Object Access Protocol (SOAP) + Web Services Description Language (WSDL) or Hypertext Transfer Protocol (HTTP)/Multipurpose Internet Mail Extensions (MIME) Multipart communication protocols. The HETS 270/271 application authenticates the Trading Partner and ensures that the Trading Partner is associated with valid National Provider IDs (NPI) in the HETS database. If the Trading Partner is not authorized, or is not associated with valid NPIs, then an appropriate error response is returned. If the Trading Partner is authorized, then the appropriate response is returned. **Figure 2** illustrates the high-level process for communicating with the HETS 270/271 application. The lock icons represent system checkpoints that must be passed before eligibility information is returned on the 271 response.

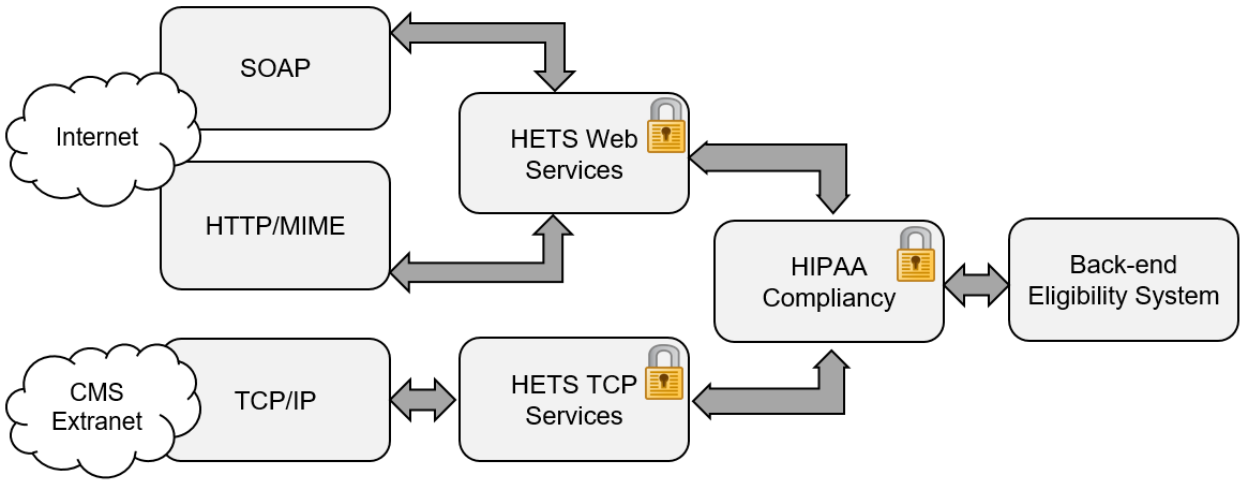

Figure 2. Transaction Process

4.2 Transmission Administrative Procedures

4.2.1 Schedule, Availability, and Downtime Notification

The HETS 270/271 application is typically available 24 hours a day, 7 days a week. At this time, there are no standing HETS 270/271 maintenance windows. MCARE will notify HETS Trading Partners of any planned downtime. All current and archived downtime notifications are available via the following page within the CMS HETS Help website: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/MCARE-Notification-Archive.html.

Any unplanned downtime with the HETS 270/271 application during Help Desk operational hours will also be communicated to the Trading Partners via email and posted to the HETS Help website, https://cms.gov/hetshelp as soon as MCARE is aware of the situation. A second follow-up email will also be sent alerting the Trading Partners when the HETS 270/271 application becomes available.

Please refer to Section 5 of this *Companion Guide* for MCARE contact information.

4.2.2 Re-Transmission Procedure

Trading Partners may call MCARE for assistance in researching problems with their transactions. However, MCARE will not edit Trading Partner eligibility data and/or resubmit transactions for processing on behalf of a Trading Partner. The Trading Partner must correct the transaction and resubmit, following the same processes and procedures of the original file.

4.3 Communication Protocol Specifications

Trading Partners may connect to the HETS 270/271 application via one of the following methods:

- TCP/IP over the CMS Extranet

  Additional information about TCP/IP connectivity over the CMS Extranet is available in Section 4.3.1.

- SOAP + WSDL (“SOAP”)
- HTTP MIME Multipart (“MIME”)

  Additional information about SOAP + WSDL or HTTP MIME Multipart connectivity is available in Section 4.3.2 through Section 4.3.4.

4.3.1 CMS Extranet

The HETS 270/271 application supports transactions through the CMS Extranet via the TCP/IP transfer protocol. Trading Partners must initiate the TCP handshake to establish a TCP/IP socket connection at the CMS data center. Trading Partners should only request to open a TCP/IP socket connection as necessary to support their active eligibility requests.

The 270 request must be sent to the connected socket session immediately after Trading Partners have successfully negotiated the socket, and the 271 response will be received on the same socket connection. Trading Partners may choose to implement a client that can listen to the same socket session for a 271 response while 270 requests are being streamed. Trading Partners should monitor the socket connection while connected to ensure that the socket remains open and viable. Trading Partners should be able to determine if a socket has prematurely terminated for any reason.

Trading Partners should only submit one transaction concurrently per socket. Transactions process linearly; therefore, submitting more than one transaction per

socket concurrently results in additional transactions queuing and delaying response time to the additional transactions.

CMS recommends that high volume Trading Partners send transactions asynchronously, that is, streaming multiple sequential requests via the single socket connection. If transactions are submitted asynchronously, Trading Partners should submit the next 270 request as soon as the response to the previous request is received. Asynchronous Trading Partners may open multiple sockets, if necessary, to support transaction volume during high volume periods.

Sending 270 requests asynchronously also improves socket efficiency. There are a finite number of available HETS 270/271 sockets, so Trading Partners should limit the number of simultaneous connections to the HETS 270/271 application.

When the last requested 271 response has been received, Trading Partners should close the socket connection immediately. The HETS 270/271 application is configured to idle connections, but only after a 5-second delay to determine if additional requests will be sent. Trading Partners will greatly improve overall socket availability if they forcefully terminate all socket requests when their transactions are complete.

Each submitted transmission must contain one 270 request with only one Interchange Control Envelope, along with a transmission wrapper, around the 270 request. The purpose of the transmission wrapper is to communicate the length of the transaction message and to indicate the end of the transmission to the HETS 270/271 application.

The outbound response transaction wrapper has the same format as the inbound transmission wrapper. The 271 response to the Trading Partner is returned in the same session in which the 270 request was submitted.

The standard format of the TCP/IP Communication Transport Protocol Wrapper, SOHLLLLLLLLLLSTX<HIPAA 270 Transaction>ETX, is represented in Table 1.

Table 1. Standard Format of the TCP/IP Communication Transport Protocol Wrapper

Element	Description	Length	Hexadecimal Value	Note(s)
SOH	Start of header	1	01	This is a required element.
LLLLLLLLLL	# of bytes, including spaces, of the 270 request	10		Right justified, zero padded. This is a required element.
STX	Start of text	1	02	This is a required element.
HIPAA 270 Transaction	Eligibility request	variable		This is a required element.
ETX	End of text	1	03	This is a required element.

An illustration of the standard format of the TCP/IP Communication Transport Protocol Wrapper is represented by Figure 3.

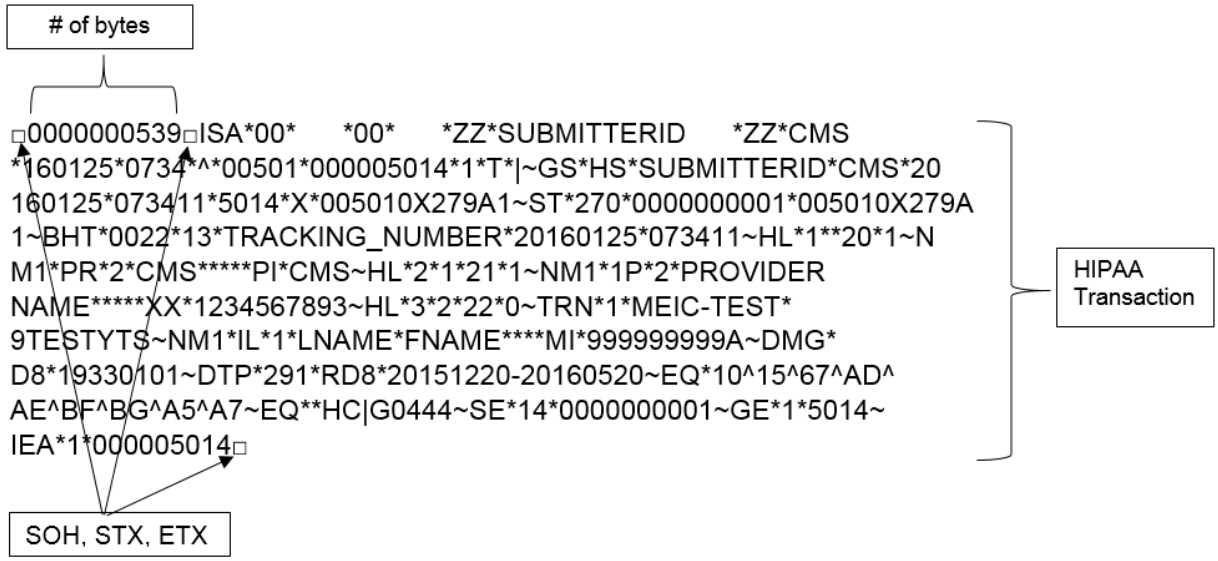

Figure 3. Example of TCP/IP Communication Transport Protocol Wrapper

Refer to the Extended Control Set matrix in the Appendix of the ASC X12 270/271 version 005010X279A1 TR3 for additional information about SOH, STX, and ETX.

4.3.2 Web Services Connectivity via SOAP + WSDL (“SOAP”) or HTTP MIME Multipart (“MIME”)

To connect to the HETS 270/271 application via SOAP or MIME, Trading Partners shall authenticate with an X.509 Digital Certificate using the Transport Layer Security (TLS) 1.2 open standard for client certificate-based authentication. TLS 1.2 is required for compliance per the federally mandated National Institute of Standards and Technology (NIST) Special Publication 800-52r1.

The Trading Partner’s originating IP address will be verified by CMS prior to allowing the 270 inquiry through to the HETS 270/271 application. Note that the Trading Partner’s originating IP address must be an address from the organization’s Production (not Testing) environment. Also note that the supplied Trading Partner originating IP address must be a public address.

The information provided in the following steps should allow the Trading Partners to locate proper digital certificates for HETS connectivity. Trading Partners will need to generate a Certificate Signing Request (CSR) for obtaining the digital certificate for their organization. The CSR generation process is platform specific. Please review the CSR generation process for your Certificate Authority (CA) carefully, as shown in the links found in the following three subsections and contact the CAs directly in order to obtain the digital certificate. CMS requires that all Trading Partners using SOAP or MIME use a SHA2-256 digital certificate.

Note: The certificates listed for each CA are the minimum level required to connect to the HETS 270/271 application. Trading Partners may choose to procure a higher level of certificate.

Before accessing the HETS 270/271 application via SOAP or MIME, new and existing Trading Partners must provide the Digital Certificate to CMS by contacting MCARE. MCARE will verify the certificate and initiate the process to configure Trading Partner access to the HETS 270/271 application. If the Trading Partner's Digital Certificate has not been approved or properly configured, the SOAP or MIME connection to the HETS 270/271 application will be rejected. The Trading Partner's same digital certificate is also required for digitally signing the SOAP message timestamp and payload fields as specified in Section 3.1.1. The SOAP response will also be digitally signed by CMS for authenticity of the message.

Trading Partners that acquire a new Digital Certificate for HETS 270/271 SOAP or MIME must provide a copy of the new Digital Certificate to CMS by contacting MCARE. The Trading Partner will also be required to complete an updated HETS Trading Partner Agreement (as outlined in Section 9) that includes the new Digital Certificate details. In order to ensure an uninterrupted transition, CMS strongly recommends that Trading Partners begin this process at least 30 days prior to the expiration of the existing Digital Certificate.

For more information on the Web Services Communication Protocol Specifications for connecting to the HETS 270/271 application, refer to the *HETS Trading Partner SOAP/MIME Connectivity Instructions* available online here: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271SOAPMIMEConnectivity.pdf.

The Trading Partners will need to procure a digital certificate from one of the following CAs detailed in the subsections below in order to allow their infrastructure to connect to the HETS servers. Information on certificate procurement and platform-specific CSR generation processes can be found on each CA's webpage. The links to their home pages has been provided below in Section 4.3.2.1 through Section 4.3.2.2.

Trading Partners must use one of the following CAs in the subsections below to procure a Digital Certificate.

4.3.2.1 DigiCert

Information on digital certificates provided by DigiCert can be found using the following link: http://www.digicert.com

Digital certificates issued by the following DigiCert Intermediate certificates are accepted:

- DigiCert SHA2 Assured ID CA
- DigiCert SHA2 Secure Server CA

- DigiCert EV RSA CA G2
- DigiCert SHA2 High Assurance Server CA
- DigiCert Assured ID CA G2
- DigiCert Global CA G2

4.3.2.2 Entrust

Information on digital certificates provided by Entrust can be found using the following link: https://www.entrust.com/digital-security/certificate-solutions/products/digital-certificates/tls-ssl-certificates

Digital certificates issued by the following Entrust Intermediate certificates are accepted:

- Entrust Certification Authority – L1K
- Entrust Certification Authority – L1M

4.3.3 SOAP + WSDL ("SOAP")

The HETS 270/271 application supports transactions formatted according to SOAP Version 1.2, conforming to standards set forth by WSDL for Extensible Markup Language (XML) envelope formatting, submission, and retrieval. The X12 payload data must be embedded using the inline method (Character Data (CDATA) element), the XML schema, and WSDL definitions formatted according to the Phase II CORE 270: Connectivity Rule. The following links should be used as reference:

4.3.3.1 SOAP XML Schema

The XML schema used by the HETS 270/271 application is available for download via the following website:

https://www.caqh.org/core/eligibility-benefits-operating-rules

4.3.3.2 WSDL Schema

The WSDL schema used by the HETS 270/271 application is available for download via the following website:

https://www.caqh.org/core/eligibility-benefits-operating-rules

4.3.3.3 CORE Connectivity Rule

The CORE Connectivity Rule is available for download via the following website:

https://www.caqh.org/core/eligibility-benefits-operating-rules

4.3.3.4 Submission/Retrieval

SOAP transactions are submitted to HETS 270/271 via a specific URL. Refer to the *HETS Trading Partner SOAP/MIME Connectivity Instructions* for additional information.

The X12 payload must be embedded using the Inline method (CDATA element) for real-time SOAP transactions. For more information, refer to the W3C recommendation on SOAP messaging framework located at: http://www.w3.org/TR/soap12-part1

4.3.3.5 SOAP Header Requirements

The SOAP Header must include the timestamp element which must be digitally signed. The Web Services Security Binary Security Token must be added to the SOAP Header which is used for verification of the signature. The CORE Connectivity Rule referenced in Section 4.3.3.3 should be used as a reference when constructing the SOAP Header.

4.3.3.6 SOAP Body Requirements

Only those characters referenced in the Basic and the Extended Character Sets noted in the Appendix of the ASCX12 270/271 version 005010X279A1 TR3 including the 005010X279E1 Errata are acceptable within a HETS 270 inquiry. The following link should be used as a reference when constructing the SOAP Body: http://www.w3.org/TR/soap12-part1

Required HETS-specific body elements for 270 requests using SOAP are defined in Table 2.

Table 2. Required Body Elements for 270 Requests Using SOAP

Element Name	Description
PayloadType	X12_270_Request_005010X279A1
ProcessingMode	Real-time
PayloadID	Refer to Section 4.4.2 of the Phase II CORE 270: Connectivity Rule for structural guidelines for CORE envelope metadata.
TimeStamp	Format is YYYY-MM-DDTHH:MM:SSZ. Refer to http://www.w3.org/TR/xmlschema11-2/ for more information.
SenderID	This is a submitter defined alphanumeric field. The value must be 10 characters in length. Recommended value is your HETS 270/271 SOAP Submitter ID plus trailing zeros for a total of 10 characters.
ReceiverID	CMS
CORERuleVersion	2.2.0
Payload	X12 request. This element must be digitally signed, and the entire payload should be enclosed within a CDATA tag.

Table 3 defines HETS-specific body elements for X12 responses using SOAP.

Table 3. Required Body Elements for X12 Responses Using SOAP

Element Name	Description
PayloadType	X12_271_Response_005010X279A1, X12_TA1_Response_00501X231A1, X12_999_Response_005010X231A1

Element Name	Description
ProcessingMode	Real-time
PayloadID	Refer to Section 4.4.2 of the Phase II CORE 270: Connectivity Rule for structural guidelines for CORE envelope metadata.
TimeStamp	Format is YYYY-MM-DDTHH:MM:SSZ. Refer to http://www.w3.org/TR/xmlschema11-2/ for more information.
SenderID	CMS
ReceiverID	This field must be 10 characters in length, the same as the 270 Sender ID.
CORERuleVersion	2.2.0
Payload	X12 response

4.3.3.7 SOAP Digital Signature

The SOAP communication protocol requires Trading Partners to embed their certificate within the eligibility request and digitally sign the SOAP Body Payload and SOAP Header Timestamp using their private key. CMS will embed their certificate in the 271 response, enabling the Trading Partner to verify it came from CMS. Trading Partners can obtain a copy of CMS' Certificate in advance by contacting the MCARE Help Desk.

Trading Partners sending via SOAP must utilize a canonicalization method algorithm for signature that is Exclusive Without Comments: http://www.w3.org/2001/10/xml-exc-c14n# . Signatures using algorithms that are Exclusive With Comments, Inclusive With Comments or Inclusive Without Comments will not be accepted.

Refer to the following link for details related to digital signatures as they relate to SOAP: http://www.w3.org/TR/SOAP-dsig/

4.3.3.8 SOAP Examples

Examples of a real time SOAP request and response can be found in Sections 4.2.2.3 and 4.2.2.4 of the CORE Phase II Connectivity Rule referenced in Section 4.3.3.3.

4.3.4 HTTP MIME Multipart ("MIME")

HETS will support standard MIME messages. The MIME format used must be multipart/form-data.

CORE does not specify the naming conventions as a mandate. HETS will implement the MIME body parts with the same field names as the SOAP element nodes. The response will be returned as MIME multipart/form-data, with the Payload body part containing the X12 response.

Submitters must specify appropriate MIME headers. The MIME specification is very precise and requires that the headers and the body be constructed perfectly. The HETS implementation of MIME allows for the use of the Basic and Extended Character Sets as noted in the Appendix of the ASCX12 270/271 version 005010X279A1 TR3 including the 005010X279E1 Errata only. Please refer to the RFC 2388 – returning values from

Forms: multipart/form-data to review header and body specifications. The RFC 2388 can be found at the following link:
http://www.faqs.org/rfcs/rfc2388.html

4.3.4.1 Submission/Retrieval

MIME transactions are submitted to HETS 270/271 via a specific URL. Refer to the HETS Trading Partner SOAP/MIME Connectivity Instructions for additional information.

A MIME transaction must be constructed exactly to the multipart/form-data specifications. Refer to http://www.faqs.org/rfcs/rfc2388.html for more information on multipart/form header and body specifications.

4.3.4.2 HTTP MIME Multipart Header Requirements

MIME messages will have standard HTTP header data elements, such as POST, HOST, Content-Length, and Content-Type. The supported Content-Type is MIME multipart/form-data.

4.3.4.3 HTTP MIME Multipart Body Requirements

Since CORE does not specify naming conventions, HETS will implement MIME with the same field names as SOAP. Required body elements for MIME transactions are defined in Table 4.

Table 4. Required Body Elements for 270 Requests Using MIME

Element Name	Description
PayloadType	X12_270_Request_005010X279A1
ProcessingMode	Real-time
PayloadID	Refer to Section 4.4.2 of the Phase II CORE 270: Connectivity Rule for structural guidelines for CORE envelope metadata.
TimeStamp	Format is YYYY-MM-DDTHH:MM:SSZ. Refer to http://www.w3.org/TR/xmlschema11-2/ for more information.
SenderID	This is a submitter defined alphanumeric field. The value must be 10 characters in length. Recommended value is your HETS 270/271 MIME Submitter ID plus trailing zeros for a total of 10 characters.
ReceiverID	CMS
CORERuleVersion	2.2.0
Payload	X12 request. The X12 request must be submitted as part of the MIME request and not as an attachment. If an attachment is received, the transaction will be rejected. The request does not need to be enclosed within a CDATA tag. See Appendix A for an example of the 270 request that would appear here.

Table 5 defines HETS-specific body elements for X12 responses using MIME.

Table 5. Required Body Elements for X12 Responses Using MIME

Element Name	Description
PayloadType	X12_271_Response_005010X279A1, X12_999_Response_005010X231A1 or X12_TA1_Response_00501X231A1
ProcessingMode	Real-time
PayloadID	Refer to Section 4.4.2 of the Phase II CORE 270: Connectivity Rule for structural guidelines for CORE envelope metadata.
TimeStamp	Format is YYYY-MM-DDTHH:MM:SSZ. Refer to http://www.w3.org/TR/xmlschema11-2/ for more information.
SenderID	CMS
ReceiverID	This field must be 10 characters in length, the same as the 270 Sender ID.
CORERuleVersion	2.2.0
Payload	X12 response

4.3.4.4 HTTP MIME Multipart Examples

Examples of a real time MIME request and response can be found in Sections 4.2.1.1 and 4.2.1.2 of the CORE Phase II Connectivity Rule referenced in Section 4.3.3.3.

4.4 Security

The HETS 270/271 application is located at a secure CMS data center. The CMS Extranet connection requires a password that is provided by the CMS-approved network reseller and features a variety of security measures to protect the integrity of the HETS 270/271 application. Trading Partners transmitting with SOAP or MIME must obtain a digital certificate and send the transaction to the HETS 270/271 application via secure internet connection. Additionally, the HETS 270/271 application authorizes Trading Partners based on either their originating Internet Protocol (IP) address or digital certificate and their CMS-issued HETS 270/271 Submitter ID.

All Trading Partners must assume full responsibility for the privacy and security of all Medicare beneficiary data. Additionally, CMS holds Clearinghouse Trading Partners responsible for the privacy and security of eligibility transactions sent directly to them from Providers and requires them to be able to associate each inquiry with a Provider. Provider authentication must be established by the Clearinghouse outside of the transaction.

5 MCARE Contact Information

All inquiries and comments regarding Trading Partner registration, connection set-up, transaction testing, and the submission of 270/271 transactions and interpretation of their data should be directed to MCARE.

MCARE is available at 1-866-324-7315 or at MCARE@cms.hhs.gov Monday through Friday, from 7:00 AM to 7:00 PM ET. The MCARE Help Desk is closed on Federal holidays.

Note: The MCARE email address is monitored during normal business hours. Emails are typically answered within one business day.

MCARE cannot assist in the resolution of benefit-related discrepancies. Questions regarding eligibility/benefit data for Medicare Part A and Part B should be directed to the appropriate regional MAC. Eligibility/benefit questions about MA, Part D, and MSP should be directed to the appropriate plan(s) identified in the 271 response.

6 Control Segments/Envelopes

The following sections describe the HETS 270/271 transaction requirements to be used in conjunction with the requirements outlined in the ASC X12 270/271 version 005010X279A1 TR3. Adhering to these requirements will help to ensure that transactions received by the HETS 270/271 application will pass the specified business edits.

All references to the ASC X12 270/271 version 005010X279A1 TR3 assume the version referenced in Section 1.1 of this *Companion Guide*.

6.1 Interchange Control Structure (ISA/IEA)

Table 6 describes the values specifically required by the HETS 270/271 application within the ISA Header of the 270 request. The HETS 270/271 application does not expect any custom values for the IEA segment within the 270 request. Please follow the rules as specified by the ASC X12 270/271 version 005010X279A1 TR3.

Table 6. 270 ISA Segment Rules

Reference	Name	X12 Codes	Notes/Comments
ISA	Interchange Control Header		
ISA01	Authorization Information Qualifier	00	HETS always expects “00.”
ISA03	Security Information Qualifier	00	HETS always expects “00.”
ISA05	Interchange ID Qualifier	ZZ	HETS always expects “ZZ.”
ISA06	Interchange Sender ID		HETS always expects the Trading Partner Submitter ID assigned by CMS.
ISA07	Interchange ID Qualifier	ZZ	HETS always expects “ZZ.”
ISA08	Interchange Receiver ID		HETS always expects “CMS.”
ISA09	Interchange Date		HETS always expects a current date.
ISA14	Acknowledgment Requested	0,1	HETS will not return the TA1 acknowledgement receipt of a real time transaction even if acknowledgment is requested.

6.2 Functional Group Structure (GS/GE)

Table 7 describes the values specifically required by the HETS 270/271 application within the GS Header of the 270 request. The HETS 270/271 application does not expect any custom values for the GE segment within the 270 request.

Please follow the rules as specified by the ASC X12 270/271 version 005010X279A1 TR3 for all elements not included in Table 7.

Table 7. 270 GS Segment Rules

Reference	Name	X12 Codes	Notes/Comments
GS	Functional Group Header		
GS02	Application Sender's Code		HETS always expects the Trading Partner Submitter ID assigned by CMS.
GS03	Application Receiver's Code		HETS always expects "CMS."

6.3 Transaction Set Header/Trailer (ST/SE)

The HETS 270/271 application does not expect any custom values for the ST/SE segments within the 270 request. Please follow the rules as specified by the ASC X12 270/271 version 005010X279A1 TR3.

7 Payer Specific Business Rules and Limitations

This section describes the business rules and limitations of the HETS 270/271 application.

All references to the ASC X12 270/271 version 005010X279A1TR3 assume the version referenced in Section 1.1 of this *Companion Guide*.

7.1 General Structural Notes

- Trading Partners should follow the ST/SE guidelines outlined in the 270 section of the ASC X12 270/271 version 005010X279A1 TR3.
- Trading Partners should follow the ISA/IEA and GS/GE guidelines for HIPAA in Appendix C of the ASC X12 270/271 version 005010X279A1 TR3 and follow the 999 and TA1 guidelines outlined in the ASC X12 version 005010X231A1 TR3.
- Trading Partners must follow the character set guidelines as defined in the Appendix of the ASC X12 270/271 version 005010X279A1 TR3.
- CMS strongly recommends that Trading Partners use the preferred 270 request delimiters in Table 8. HETS will utilize these delimiters for all 271 responses (regardless of the delimiters the Trading Partner sent in the 270 request).

Table 8. Preferred 270 Request Delimiters

Character	Name	Delimiter
*	Asterisk	Data Element Separator
|	Pipe	Component Element Separator
~	Tilde	Segment Terminator
^	Carat	Repetition Separator

- Each transaction must contain only one Patient Request. Each 270 request must have only one ISA/IEA, one GS/GE, one ST/SE, and a single 2100C Subscriber Loop

7.2 General Transaction Notes

Eligibility/Benefit for Medicare Advantage (MA)

Questions regarding eligibility, coverage, and payment for Medicare Advantage (MA) should be directed to the appropriate MA plan(s) identified in the eligibility response. Each MA plan can have different out-of-pocket costs and specific rules for getting and billing services. You must follow the MA plan's terms and conditions for payment.

- The HETS 270/271 application data is updated once daily (early in the morning, Eastern Time). The HETS 271 response is not updated further during the course

of a day. Trading Partners should not resubmit the same transaction multiple times during the course of a day expecting to receive different results.

- The 271 response returns the following basic set of eligibility information if the Medicare beneficiary is entitled to Part A and/or Part B for all valid 270 requests.
    - Medicare beneficiary demographics
    - Part A and B entitlement including any Periods of Inactivity
    - The most recent Part A and B entitlement/enrollment reason code for each type of coverage
    - Coverage status of requested and supported STCs
    - MSP, MA, and Part D plan enrollment information (where applicable)
    - Plan level financial information
- The HETS 270/271 application will accept multiple Service Type Codes (STCs) and/or Healthcare Common Procedure Coding System (HCPCS) codes on a 270 request.
- Additional eligibility information will be returned when the following supported STCs are sent within a 270 request: AD, AE, AF, AG, A5, A7, BD, BF, BG, CO, CQ, RN, 10, 42, 45, 47, 48, 49, 64, 67 and 80[1].
- Additional eligibility information returns when the following supported HCPCS Codes are sent within a 270 request: 71271, 76706, 76977, 77067, 77078, 77080, 77081, 80061, 81528, 82270, 82465, 82947, 82950, 82951, 83718, 84478, 90670, 90671, 90677, 90732, 92550, 92552, 92553, 92555, 92556, 92557, 92562, 92563, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92601, 92602, 92603, 92604, 92620, 92621, 92625, 92626, 92627, 92640, 92651, 92652, 92653, G0101, G0102, G0103, G0104, G0105, G0106, G0117, G0118, G0120, G0121, G0123, G0130, G0143, G0144, G0145, G0147, G0148, G0327, G0328, G0402, G0403, G0404, G0405, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0472, G0473, G0475, G0476, G0499, P3000, and Q0091[1].
- The 271 response returns the Medicare coverage status for the following supported STCs when sent within a 270 request: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, 15, 18, 20, 23, 24, 25, 26, 27, 28, 30, 33, 35, 36, 37, 38, 39, 40, 41, 42, 45, 47, 48, 49, 50, 51, 52, 53, 54, 62, 64, 65, 67, 68, 69, 73, 76, 78, 80, 81, 82, 83, 86, 88, 93, 98, 99, A0, A3, A4, A5, A6, A7, A8, AD, AE, AF, AG, AI, AJ, AK, AL, BD, BF, BG, BH, BT, BU, BV, CO, CQ, DM, MH, RN, and UC.

[1] CMS reminds HETS Submitters that the ASC X12 270/271 version 005010X279A1 standard allows a maximum of 99 EQ segments to be submitted on a 270 request. If a HETS Submitter attempts to send every supported HCPCS code on a 270 request plus several separate EQ segments for Service Type Codes (STCs), then the Submitter may exceed 99 EQ segments. Per the standard, HETS will respond with a 999 response if the 270 request includes more than 99 EQ segments.

- All supported, benefit specific Service Type Codes or HCPCS Codes submitted on the 270 requests will return as inactive benefits on the 271 response when the Medicare beneficiary is enrolled in the Part B Immunosuppressive Drug Benefit (Part B-ID) program for the requested Date(s) of Service. See Section 7.26 for additional information.
- The 271 response only returns the coverage status of the “child” components of STCs 1, 30, 35, 47 and/or MH if they are sent within a 270 request. If the requested date(s) of service start date is after the Date of Death, then the “child” components are not returned. The “child” components are not returned when the Medicare beneficiary is ineligible. The “child” component STCs are defined in the Front Matter of the ASC X12 270/271 version 005010X279A1 TR3.
- The 271 response returns STCs 1, 47, and MH when requested on the 270 and the Medicare beneficiary is ineligible for Medicare Part A. The 271 response returns STCs 1, 35, 47, and MH when requested on the 270 and the Medicare beneficiary is ineligible for Medicare Part B.
- The 271 response returns the following supported STCs as covered under Medicare Part A: 10, 15, 42, 45, 48, 49, 65, 69, 76, 78, 83, A5, A7, AG, BT, BU, BV, and RN. The coverage status of the Part A covered STCs is returned in the EB01 data element of the Part A entitlement 2110C loop.
- The 271 response returns the following supported STCs as covered under Medicare Part B: 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, 18, 20, 23, 24, 25, 26, 27, 28, 33, 36, 37, 38, 39, 40, 42, 50, 51, 52, 53, 62, 64, 65, 67, 69, 73, 76, 78, 80, 81, 83, 86, 93, 98, 99, A0, A3, A4, A6, A8, AD, AE, AF, AI, AJ, AK, AL, BD, BF, BG, BH, BT, BU, BV, CO, DM, RN and UC. The coverage status of the Part B covered STCs is returned in the EB01 data element of the Part B entitlement 2110C loop.
- The 271 response returns the following supported STCs as not covered (EB01= “I”) under Medicare: 41, 54, 68, and 82.
- When STC 30 is submitted on a 270 request, the 271 response returns the coverage status of the following STCs: 2, 3, 23, 24, 25, 26, 27, 28, 33, 36, 37, 38, 39, 40, 41, 42, 45, 48, 49, 50, 51, 52, 53, 54, 67, 69, 73, 76, 83, 86, 88, 98, A4, A5, A6, A7, A8, AG, AI, AJ, AK, AL, BT, BU, BV, DM, UC.
- The following scenarios will also produce a response as though STC 30 was requested.
    - No STC is requested
    - A requested STC is not supported by HETS
    - A requested HCPCS code is not supported by HETS
- When STC 80 is submitted on a 270 request, the 271 response typically returns separate 271 2110C EB & DTP loops specifically stating plan level eligibility for COVID-19 vaccination. The 271 2110C DTP loop will always return the current HETS system date. HETS handles STC CO in a similar way for Influenza (Flu)

vaccination. If both STC 80 and CO are submitted on a 270 request, the 271 response will combine the plan level eligibility for COVID-19 and Flu vaccination. Refer to Section 7.24 for additional details.

- The 271 response returns the Medicare beneficiary's Part D coverage status with STC 88 in a separate 2110C loop when STC 88 or 30 is specifically requested or if the HETS 270/271 application is responding as if STC 30 was requested.
- The following STCs are free services and are covered at 100% by Medicare Part A and/or Part B; therefore, deductibles, copayment, and coinsurance liabilities do not apply: 5, 42, 45, 67, 80, AJ, and CO. The 271 response returns all Part A free service information in a single 2110C EB loop with the potential for multiple DTP segments, regardless of what calendar year they fall within. With the exception of STC 80 and CO, HETS handles Part B free service information in the same manner as a single 271 2110C EB loop with the potential for multiple DTP segments. STC 80 financial liability information for COVID-19 vaccination will only be returned for the current year. STC CO financial liability information for Influenza (Flu) vaccination will only be returned for the current year.
- The 271 response returns an additional 2110C loop for any STC where the deductible and/or coinsurance amounts differ from the Plan Level amounts.
- The 271 response returns the coverage status for STCs 48 and 49 when STCs AG, 47, 48, and/or 49 are sent within a 270 request except when the requested date(s) of service start date is after the Date of Death or the Medicare beneficiary is ineligible.
- The 271 response will include a specific and separate 2110C EB loop which contains a yes or no value indicating if a prior authorization is required by Medicare for the first 10 HCPCS submitted on the 270 request. If more than 10 HCPCS codes are submitted on the 270, any additional codes will not receive these authorization details. HETS submitters that wish to utilize this functionality need to review the order in which they submit HCPCS codes in their 270 request.
    - HETS will select the first 10 HCPCS codes submitted in the 270 request. HETS will then drop any HCPCS codes from this group if that HCPCS code can already be returned on the HETS 271 response for preventive, PPV, or any other benefit. If any HCPCS codes remain, the HETS response will then provide separate 271 2110 EB loops for each remaining HCPCS code from the first 10 submitted. Example loop returned in a 271 response:

      EB*D**********Y**HC|15820~ (EB11 = Prior Authorization Y/N Indicator for HCPCS 15820)
    - The HETS 271 response indicating if a prior authorization is required for a HCPCS codes is informational only and is in no way a guarantee of coverage or payment for that service. The HETS 271 response is based upon information obtained from the CMS database at the time of inquiry and is never considered a guarantee of payment.

- See Table 50 for additional information.

- The 271 response may return multiple EB loops to reflect the Medicare beneficiary's plan level financials, benefit, and enrollment history and/or the EQ values sent within a 270 request.
- The 271 response does not include 2110C loops for future year deductibles, coinsurance, and copayment per day when these values have not yet been published by CMS. The 271 response is based upon information obtained from the CMS database at the time of inquiry and is not considered a guarantee of payment.
- The 271 response will include the DOEBA and DOLBA dates of all hospital spells intersecting the current date and/or the calendar (years) of the date/date range of the 270 request. This data returns in the HETS 271 response for any specific Service Type Code (STC) or HCPCS code in the 270 request. Example segments returned in a 271 response:

  EB*D**30*MA~
  DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = DOEBA and DOLBA Dates)

- Trading Partners receive a 271 response 2100A AAA error with a reject reason code of AAA03 = "42" when the HETS 270/271 application is unable to process a single transaction in less than 60 seconds or when other system issues are encountered.
- The HETS 270/271 application returns a 999 error response if dependent-level data is sent within a 270 request.

7.3 Medicare Beneficiary Matching Rules

The HETS 270/271 application applies search logic that uses a combination of the following data elements: Medicare Beneficiary Identifier (MBI), Medicare beneficiary's Date of Birth (DOB), Medicare beneficiary's full last name, and Medicare beneficiary's full first name. Trading Partners should not submit any additional beneficiary data elements in an attempt to generate a match. Table 9 describes the necessary data elements for the required primary and alternate search options supported by the HETS 270/271 application.

Table 9. HETS 270/271 Search Options

Search Option	MBI	Last Name	First Name	DOB
Primary	X	X	X	X
Alternate 1	X	X		X
Alternate 2	X	X	X	

- The HETS 270/271 application only accepts the MBI as the Subscriber Primary Identifier value on 270 requests. HETS 270/271 will reject any requests that are submitted with a Medicare Health Insurance Claim Number (HICN). The HETS

271 response to any 270 request that contains a HICN would be no better than a 271 2100C AAA03 = “72” for an invalid Member ID.

- If the individual with coverage qualifies for Medicare under RRB, the HETS 271 response includes a 2110C MSG segment of “Railroad Retirement Medicare Beneficiary.”
- Medicare beneficiary MBI numbers can be replaced in specific circumstances. If a Medicare beneficiary’s MBI number has been changed, then the HETS 270/271 application will accept historical 270 requests with either a) the new MBI or b) the old MBI number only if the old MBI was active during the Date(s) of Service submitted on the request. HETS does not cross-reference MBIs.
- If applicable, the HETS 270/271 application returns a MBI’s end date on 271 responses that a) contain benefit information and b) include a Date(s) of Service which overlaps the terminated MBI’s effective period. Medicare Providers/Suppliers should contact the Medicare beneficiary to obtain an updated MBI number. HETS does not cross-reference MBIs.
- If the Trading Partner submits a beneficiary’s middle name or initial in the 270 2100C NM105 or a gender code in the 270 2100C DMG03, then the HETS 270/271 application returns a 999 response. Additionally, HETS rejects any requests where the 270 2100C REF01 contains a value of ‘SY’. Trading Partners should not submit any additional beneficiary data elements outside of those listed above in Table 9.
- If the search criteria do not produce a match to a Medicare beneficiary, the 271 response includes the appropriate AAA03 error code in the 271 response. Refer to Section 8.3 of this *Companion Guide* for additional information.

7.4 Date Request Rules

- The 271 response returns current eligibility information if no date is contained in the 270 request.
- CMS will verify that the date(s) requested on the 270 request are within the HETS 270/271 application’s allowable date span. The allowable date span is up to four years in the past and up to four months in the future, based on the date the transaction was received. If requests are outside of this range, the HETS 270/271 application returns a AAA error in the 2100C Loop with a reject reason code of AAA03 = “62.”
- Eligibility requests submitted for the maximum allowable date span take longer to process and return significantly more eligibility data on the 271 response. CMS urges HETS 270/271 Submitters to carefully consider which, if any, circumstances should 270 requests contain the maximum allowable date span. CMS discourages HETS Submitters from defaulting to the maximum allowable date span on all eligibility requests.

Table 10 illustrates the allowable request date ranges.

Table 10. Request Date Calendar

If the Current Month Is:	Historical Requests Are Valid Through:	Future Requests Are Valid Through:
January	January, 4 years ago	May of the current year
February	February, 4 years ago	June of the current year
March	March, 4 years ago	July of the current year
April	April, 4 years ago	August of the current year
May	May, 4 years ago	September of the current year
June	June, 4 years ago	October of the current year
July	July, 4 years ago	November of the current year
August	August, 4 years ago	December of the current year
September	September, 4 years ago	January of the following year
October	October, 4 years ago	February of the following year
November	November, 4 years ago	March of the following year
December	December, 4 years ago	April of the following year

Example: If an eligibility request is sent on March 1, 2022, requests from March 1, 2018 through July 1, 2022 will be accepted.

7.5 Medicare Part A & Part B Eligibility Business Rules

7.5.1 HETS 270/271 Business Rules

- Trading Partners should review the entire 271 response to determine the appropriate eligibility status for the Medicare beneficiary.
- To indicate periods of Medicare entitlement, the 271 response returns a 2110C loop with element EB01 = “1” along with applicable EB03 covered STCs and the Subscriber Eligibility/Benefit Date (DTP03) where DTP01 = “291” with beginning and end dates, where appropriate, for each applicable entitlement period.
- The 271 response returns a 2110C loop with element EB01= “6” for Part A and/or Part B along with applicable EB03 covered STCs without the DTP segments for either of the following reasons:
    - The Medicare beneficiary’s Part A and/or Part B entitlement had not yet begun as of the requested date(s) of service.
    - The Medicare beneficiary’s Part A and/or Part B entitlement has terminated prior to the requested date(s) of service.

The 271 response may return the Medicare beneficiary’s most recent entitlement or enrollment reason code for Medicare Part A and Medicare Part B coverage. If applicable, the 271 response would include the most recent entitlement or enrollment reason that is available for each type of coverage. Entitlement or enrollment reason will

not be returned for prior entitlement periods with the same entitlement or enrollment reason.

The Medicare beneficiary entitlement/enrollment reason code is returned as a 271 2110C MSG segment where the MSG would read as follows:

MSG*(*Medicare Entitlement/Enrollment Reason Code*) – (*Medicare Entitlement/Enrollment Code Text Value*)

The Medicare Entitlement/Enrollment reason codes and their corresponding text values are:

Table 11. Medicare Entitlement/Enrollment Reason Codes

Medicare Entitlement/ Enrollment Reason Code	Medicare Entitlement/ Enrollment Code Text Value
0	Beneficiary insured due to age OASI
1	Beneficiary insured due to disability
2	Beneficiary insured due to End Stage Renal Disease ESRD
3	Beneficiary insured due to disability and current ESRD
P	Part B Immunosuppressive Drug Benefit

- When STC = “80” is submitted on a 270 request, the 271 response will always return separate 271 2110C EB & DTP loops specifically stating plan level eligibility for COVID-19 immunization. This 271 2110C DTP loop will always return the current HETS system date. Refer to Section 7.24 for additional details.
- The 271 response returns a 2110C loop with element EB01 = “6” along with a DTP segment containing beginning and end dates for the period of inactivity when an individual entitled to Medicare is ineligible for Medicare benefits over a period of time for any one the following reasons:
    - The Medicare beneficiary has been classified as an illegal alien in the United States.
    - The Medicare beneficiary has been deported from the United States.
    - The Medicare beneficiary has been incarcerated.
    - **Note:** Information specifying the reason for the period of ineligibility will not be released.
- Multiple periods of a Medicare beneficiary’s inactive Medicare enrollment may be returned in a 271 response if they occur during the requested date(s) of service.
- If STC “CQ” is requested in the 270 request (and all other Medicare beneficiary data in the 270 creates a match), then the 271 response returns eligibility

information for STC “CQ” separately from all other supported STCs. This separate eligibility loop reflects the coverage for the requested Date(s) of Service submitted on the 270 request.

- Medicare beneficiaries that are actively enrolled in the Part B Immunosuppressive Drug Benefit (Part B-ID) only have coverage for immunosuppressive drugs; no other items or services are covered. Medicare Part A and Part D coverage will return as inactive for Part B-ID beneficiaries.
- Example segments returned in a 271 response:

Part A Entitlement

EB*1**30^42^45^48^49^69^76^83^A5^A7^AG^BT^BU^BV^RN*MA~
DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = entitlement and termination dates (where applicable))
MSG*0 – Beneficiary insured due to age OASI~ (Part A entitlement code and reason)

Part B Entitlement

EB*1**30^2^3^23^24^25^26^27^28^33^36^37^38^39^40^42^50^51^52^53^64^67^69^73^76^83^86^98^A4^A6^A8^AI^AJ^AK^AL^BT^BU^BV^DM^RN^UC*MB~
DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = entitlement and termination dates (where applicable))
MSG*0 – Beneficiary insured due to age OASI~ (Part B entitlement/enrollment code and reason)
EB*1**80*MB~ (Separate Part B eligibility for STC “80” immunization)
DTP*771*D8*CCYYMMDD~ (Current HETS system date)

Entitled but Inactive Due to Incarceration, Deportation or Alien Status

Inactive Period

EB*6**30~
DTP*307*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = inactive date(s))
Entitlement Period

EB*1**30^42^45^48^49^69^76^83^A5^A7^AG^BT^BU^BV^RN*MA~
DTP*291*D8*CCYYMMDD~ (DTP03 = Part A entitlement date(s))
MSG*1 – Beneficiary insured due to disability~ (Part A entitlement code and reason)
EB*1**30^2^3^23^24^25^26^27^28^33^36^37^38^39^40^42^50^51^52^53^64^67^69^73^76^83^86^98^A4^A6^A8^AI^AJ^AK^AL^BT^BU^BV^DM^RN^UC*MB~
DTP*291*D8*CCYYMMDD~ (DTP03 = Part B entitlement date(s))
MSG*1 – Beneficiary insured due to disability~ (Part B entitlement/ enrollment code and reason)
EB*1**80*MB~ (Separate Part B eligibility for STC “80” immunization)
DTP*771*D8*CCYYMMDD~ (Current HETS system date)

Part B Immunosuppressive Drug Benefit Enrollment Only

EB*6**88~ (Inactive Medicare Part D entitlement)
EB*6**30*MA~ (Inactive Medicare Part A entitlement)
EB*1**30*MB~ (Active Medicare Part B-ID enrollment)
DTP*291*D8*20230101~ (DTP03 = Part B-ID entitlement effective date)
MSG*P-Part B Immunosuppressive Drug Benefit~ (MSG01 = Part B-ID enrollment reason code and text value)

For additional information, refer to Table 25.

7.5.2 HETS Date of Death Business Rules

The HETS 270/271 application utilizes entitlement data (including Date of Death) from the Social Security Administration. The combination of the requested date(s) of service on the 270 request and the recorded Date of Death dictates the manner in which the HETS 271 response uses the Date of Death.

- If the requested dates(s) of service are **on or before** the recorded Date of Death, the HETS 271 response will return normal eligibility information for the date(s) up until the Date of Death. The HETS 271 response will also include a separate 2100C DTP segment that contains the Date of Death.
- If the requested date(s) of service are **after** the recorded Date of Death the HETS 271 response will note that the beneficiary is ineligible by returning a 2110C loop with element EB01= “6”, EB03 = “30” plus any covered STCs from the 270 request that are supported by HETS. STCs that are supported by HETS but are not covered for the Medicare beneficiary will be returned in the 271 response as non-covered.

Figure 4 illustrates handling of Date of Death based on the date(s) of service submitted on the 270 request.

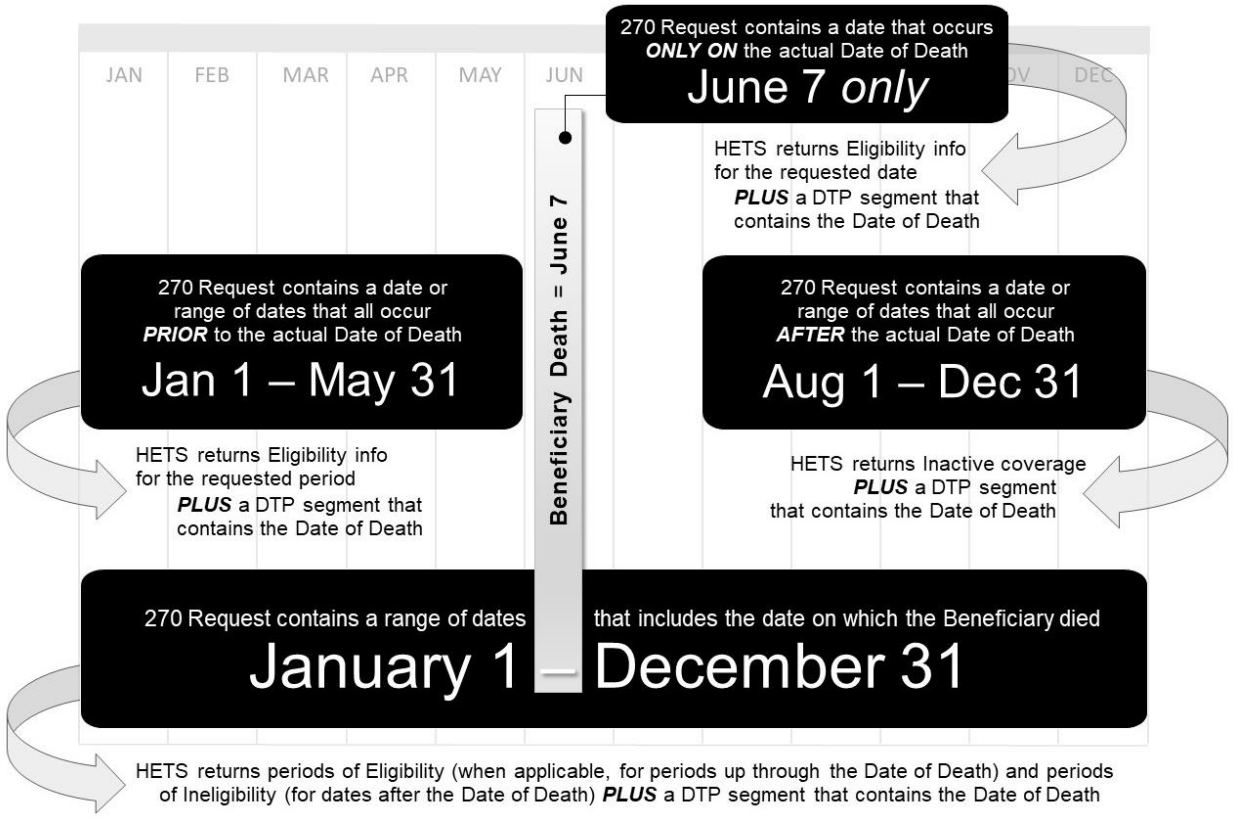

Figure 4. Date of Death Business Rules

The HETS 271 response is also modified in several ways (listed below) to either limit the 271 response or reflect ineligibility for particular services when a Medicare beneficiary has a Date of Death on file:

- The HETS 271 response does not return coverage status of the “child” components of STCs 1, 30, 35, 47 and/or MH if the requested date(s) of service start date is after the Date of Death, then the “child” components are not returned. The “child” component STCs are defined in the Front Matter of the ASC X12 270/271 version 005010X279A1 TR3.
- The HETS 271 response does not include coverage status for STCs 48 and 49 when the requested date(s) of service start date is after the Date of Death.
- The HETS 271 response does not include preventive service information if the Medicare beneficiary has a Date of Death on file at the time of the 270 request.
- The HETS 271 response does not include smoking/tobacco cessation counseling benefits if the Medicare beneficiary has a Date of Death on file at the time of the 270 request.

- The HETS 271 response does not include coverage status for STCs AE and AF when the requested date(s) of service start date is after the Date of Death.
- Example segments returned in a 271 response:

  Inactive Due to Date of Death

  DTP*442*D8*CCYYMMDD~ (DTP03 = Date of Death)
  EB*6**30^10~
  EB*I**30^41~

For additional information, refer to Table 25.

7.6 Medicare Plan Level Part A Deductible Business Rules

- The 271 response returns the following Part A Plan Level financial information in the 2110C loop on every 271 response when the Medicare beneficiary is Part A entitled:
  - The base Part A deductible amount for every calendar year of the date/date range on the 270 request plus the start year of the earliest intersecting spell.
  - The remaining Part A deductible amount for every calendar year within the date/date range on the 270 request plus the start year of the earliest intersecting spell.
  - The remaining Part A deductible amount and applicable DOEBA/DOLBA dates for every spell that intersects within 60 days of the date/date range on the 270 request.
- The 271 response returns the Part A deductible as zero in an additional 2110C loop for STCs 42 or 45 when applicable and the Medicare beneficiary is Part A entitled.
- Example segments returned in a 271 response:

  Part A Deductible Financial Data

  EB*C**30*MA**26*1556~ (EB07 = Part A Base Deductible 2022)
  DTP*291*RD8*20220101-20221231~ (Dates within calendar year when no QMB enrollment is present)
  EB*C**30*MA**26*1484~ (EB07 = Part A Base Deductible 2021)
  DTP*291*RD8*20210101-20211231~ (Dates within calendar year when no QMB enrollment is present)
  EB*C**30*MA**29*1556~ (EB07 = Part A Base Deductible as Remaining 2022)
  DTP*291*RD8*20220101-20221231~ (Dates within calendar year when no QMB enrollment is present)
  EB*C**30*MA**29*1484~ (EB07 = Part A Base Deductible as Remaining 2021)
  DTP*291*RD8*20210101-20211231~ (Dates within calendar year when no QMB enrollment is present)

EB*C**30*MA**29*0~ (EB07 = Part A Spell Remaining)
DTP*291*RD8*20210101-20210106~ (Dates within DOEBA-DOLBA when no QMB enrollment is present)

Covered at 100% -- Part A

EB*C**42^45*MA**26*0~ (EB07 = 0 to display the Part A Base Deductible is not applicable)
DTP*292*RD8*20220101-20221231~ (Dates within calendar year when no QMB enrollment is present)
DTP*292*RD8*20210101-20211231~ (Dates within calendar year when no QMB enrollment is present)

For additional information, refer to Table 26.

7.7 Medicare Plan Level Part B Deductible and Coinsurance Business Rules

The purpose of this section is to explain the HETS 270/271 application business rules for Part B deductible and coinsurance amounts. Section 7.7.1 illustrates the business rules for STCs. Section 7.7.2 illustrates the business rules for supported HCPCS codes.

7.7.1 STC Financial Business Rules

- The 271 response returns the following Part B Plan Level financial information in the 2110C loop on every 271 response when a supported STC, non-supported STC, or no STC is submitted, and the Medicare beneficiary is Part B entitled:
    - The Part B base deductible amount for every calendar year within the date/date range on the 270 request.
    - The Part B remaining deductible amount for every calendar year within the date/date range on the 270 request.
    - The Part B coinsurance amount for every calendar year within the date/date range sent within a 270 request.
- Medicare beneficiaries that are enrolled in the Part B Immunosuppressive Drug Benefit (Part B-ID) program are responsible for Part B deductible and coinsurance payment. The 271 response for Part B-ID periods will include Medicare Part B deductible and coinsurance financials for STC 30 only. Part B-ID only covers immunosuppressive drugs; no other items or services are covered.
- The 271 response returns the Part B deductible and coinsurance percentage as zero dollar free services for STC 5, 42, 67, 80, AJ, and/or CO in an additional 2110C loop when the Medicare beneficiary is Part B entitled and any of the following conditions exist on the 270 request.
    - STCs 5, 42, 67, 80, AJ, or CO are explicitly requested
    - STCs 1, 30 or MH are requested
    - HETS responds as if STC 30 was requested - refer to Section 7.2

- Deductible and coinsurance are not applicable for STC 80 COVID-19 vaccination. Financial liability information for STC 80 COVID-19 vaccination will only be returned for the current year.
- Deductible and coinsurance are not applicable for STC CO Influenza (Flu) vaccination. Financial liability information for STC CO Flu vaccination will only be returned for the current year.
- Example segments returned in a 271 response:

Part B Deductible Financial Data

EB*C**30*MB**23*233~ (EB07 = Part B Base Deductible 2022)
DTP*291*RD8*20220101-20221231~ (Dates within calendar year when no QMB enrollment is present)
EB*C**30*MB**23*203~ (EB07 = Part B Base Deductible 2021)
DTP*291*RD8*20210101-20211231~ (Dates within calendar year when no QMB enrollment is present)
EB*C**30*MB**29*0~ (EB07 = Part B Remaining Deductible 2022)
DTP*291*RD8*20220101-20221231~ (Dates within calendar year when no QMB enrollment is present)
EB*C**30*MB**29*0~ (EB07 = Part B Remaining Deductible 2021)
DTP*291*RD8*20210101-20211231~ (Dates within calendar year when no QMB enrollment is present)
EB*A**30*MB**27**.2~ (EB08 = Plan Level Coinsurance Percentage 2021)
DTP*291*RD8*20220101-20221231~ (Dates within calendar year when no QMB enrollment is present)
EB*A**30*MB**27**.2~ (EB08 = Plan Level Coinsurance Percentage 2020)
DTP*291*RD8*20210101-20211231~ (Dates within calendar year when no QMB enrollment is present)

Covered at 100% -- Part B

EB*C**5^42^67^80^AJ^CO*MB**23*0~ (EB07 = 0 to display the Part B Base Deductible is not applicable)
DTP*292*RD8*20220101-20221231~ (Dates within calendar year when no QMB enrollment is present)
EB*C**5^42^67^AJ*MB**23*0~ (EB07 = 0 to display the Part B Base Deductible is not applicable)
DTP*292*RD8*20210101-20211231~ (Dates within calendar year when no QMB enrollment is present)
EB*A**5^42^67^80^AJ^CO*MB**27*0~ (EB07 = 0 to display the Part B Coinsurance is not applicable)
DTP*292*RD8*20220101-20221231~ (Dates within calendar year when no QMB enrollment is present)
EB*A**5^42^67^AJ*MB**27*0~ (EB07 = 0 to display the Part B Coinsurance is not applicable)

DTP*292*RD8*20210101-20211231~ (Dates within calendar year when no QMB enrollment is present)

For additional information, refer to Table 27.

7.7.2 Medicare HCPCS Code Financial Business Rules

The 271 response returns Part B HCPCS financial data in the 2110C loop with the current system transaction processing date for the supported HCPCS code submitted when:

- The next eligible date year is prior to or equal to the current year. The current year is determined by the year of the system date on which the 270 request is received by the HETS 270/271 application.
- The beneficiary is not dual-eligible for both Medicare and Medicaid (QMB) as of the current system transaction processing date. Refer to Section 7.21 for additional information.
- Example segments returned in a 271 response:

  Part B Deductible Amount:

  EB*C***MB**23*0******HC|80061~ (EB07 = Deductible Amount of “0”, EB13-2 = HCPCS Code)
  DTP*292*D8*CCYYMMDD~ (DTP03 = the current system transaction processing date)

  Part B Coinsurance Amount:

  EB*A***MB**27*0******HC|80061~ (EB07 = Coinsurance Amount of “0”, EB13-2 = HCPCS Code)
  DTP*292*D8*CCYYMMDD~ (DTP03 = the current system transaction processing date)

For additional information, refer to Table 28 and Table 29.

7.8 Medicare Part A Hospital and Skilled Nursing Facility (SNF) Spells Business Rules

- STC 47, 48, 49, AG, A5 or A7 must be sent within a 270 request to receive Hospital Spell data in the 271 response.
  - Prior Hospital stay dates and the rendering facility NPI.
  - Hospital Base days and Hospital remaining days and copayment amounts return with Hospital Spell data.
  - Lifetime reserve base days, Lifetime remaining days and copayment amount return with Hospital Spell data.
- STC AG must be sent within a 270 request to receive SNF data in the 271 response.
  - A SNF stay will always be accompanied by a prior Hospital stay.

    - Prior SNF stay dates and the rendering facility NPI.
    - Hospital Base days and Hospital remaining days and copayment amounts return with SNF Spell data.
- The 271 response returns all Hospital/SNF spells that fall within 60 days of the date or date range specified in the 270 request.
- If a single Hospital/SNF spell spans more than one calendar year, the 271 response returns the daily copayment amounts associated with the beginning year of the spell.
- If there is no Hospital/SNF spell within 60 days of the requested date(s) of service, the 271 response returns default values for Part A Spell data.
- The dates of a Hospital/SNF spell (2110C loop, Element DTP01 = “435”) return as the Date of Earliest Billing Activity (DOEBA) through the Date of Latest Billing Activity (DOLBA) for the overall spell.
- In addition to the Hospital/SNF spell DOEBA-DOLBA, the 271 response also includes dates of individual Hospital/SNF stays within the complete spell if the necessary STCs are included in the 270 request.
    - Different stay types (Hospital or SNF) will be returned in separate 271 EB loops.
    - If there are multiple stays with the same rendering NPI during one spell, the 271 response will return multiple DTP segments (representing multiple stays) under one EB loop. If there are more than 20 stays for the same rendering NPI during one spell, then multiple EB loops will be present.
    - Multiple spells or stays are grouped by spell and returned in following order :
        - Hospital stays in descending order (most recent first) then
        - SNF stays in descending order (most recent first)
- Overlapping Hospital spells may indicate a change in Medicare beneficiary primary entitlement from Medicare Part A to an MA plan. Please review the response to determine if the Medicare beneficiary is covered by Medicare Part A or an MA plan.
- STC A7 must be sent within a 270 request to receive Lifetime Psychiatric Limitation Data for Psychiatric Base Days and Psychiatric Remaining Days in the 271 response.
- Example segments returned in a 271 response:

  Part A Hospital/SNF Spell and Stay Dates

  EB*D**30*MA~
  DTP*292*RD8*2021315-20210705~ (DTP03 = Spell DOEBA-DOLBA)
  EB*D**48*MA~ (Hospital Stay)

DTP*435*RD8*20210315-20210327~ (DTP03 = Hospital Start & End Dates)
LS*2120~
NM1*FA*2******XX*1234567893~ (NM109 = billing Hospital NPI)
LE*2120~
EB*D**AH*MA~ (SNF Stays 1-3)
DTP*435*RD8*20210605-20210705~ (DTP03 = SNF Start & End Dates)
DTP*435*RD8*20210405-20210605~ (DTP03 = SNF Start & End Dates)
DTP*435*RD8*20210327-20210405~ (DTP03 = SNF Start & End Dates)
LS*2120~
NM1*FA*2******XX*1234567894~ (NM109 = billing SNF NPI)
LE*2120~

Hospital Days Base

EB*B**30*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A Spell)
HSD***DA**30*0~ (From Day 1)
HSD***DA**31*60~ (Thru Day 60)
HSD*****26*1~ (Per Part A Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)
EB*B**30*MA**7*389~ (EB07 = $ for 2022 Medicare Part A Copayment Days)
HSD***DA**30*60~ (From Day 61)
HSD***DA**31*90~ (Thru Day 90)
HSD*****26*1~ (Per Part A Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

Hospital Days Base as Remaining

EB*B**30*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A Spell)
HSD***DA**29*60~ (60 Days Remaining at $0 per Day)
HSD*****26*1~ (Per Part A Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)
EB*B**30*MA**7*389~ (EB07 = $ for 2022 Medicare Part A Copayment Days)
HSD***DA**29*30~ (30 Days Remaining at $ Amt per Day)
HSD*****26*1~ (Per Part A Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

Hospital Spell Days Remaining

EB*B**30*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A Spell)
HSD***DA**29*56~ (56 Days Remaining at $0 per Day)
HSD*****26*1~ (Per Part A Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (DOEBA-DOLBA) (Dates within DOEBA-DOLBA when no QMB enrollment is present)

EB*B**30*MA**7*389~ (EB07 = $ for 2022 Medicare Part A Copayment Days)
HSD***DA**29*30~ (30 Days Remaining at $ Amt per Day)
HSD*****26*1~ (Per Part A Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (DOEBA-DOLBA) (Dates within DOEBA-DOLBA when no QMB enrollment is present)

SNF Days Base

EB*B**AG*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A SNF Spell)
HSD***DA**30*0~ (From Day 1)
HSD***DA**31*20~ (Thru Day 20)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)
EB*B**AG*MA**7*194.5~ (EB07 = $ Amt for 2022 Medicare Part A Copayment Days)
HSD***DA**30*20~ (From Day 21)
HSD***DA**31*100~ (Thru Day 100)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

SNF Days Base as Remaining

EB*B**AG*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A SNF Spell)
HSD***DA**29*20~ (20 Days Remaining at $0 per Day)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)
EB*B**AG*MA**7*194.5~ (EB07 = $ Amt for 2022 Medicare Part A Copayment Days)
HSD***DA**29*80~ (80 Days Remaining at $ Amt per Day)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

SNF Spell Days Remaining

EB*B**AG*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A SNF Spell)
HSD***DA**29*18~ (18 Days Remaining at $0 per Day)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (DOEBA-DOLBA) (Dates within DOEBA-DOLBA when no QMB enrollment is present)
EB*B**AG*MA**7*194.5~ (EB07 = $ Amt for 2022 Medicare Part A Copayment Days)
HSD***DA**29*80~ (80 Days Remaining at $ Amt per Day)
HSD*****26*1~ (Per SNF Spell)

DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (DOEBA-DOLBA) (Dates within DOEBA-DOLBA when no QMB enrollment is present)

Lifetime Reserve Days

EB*K**30*MA**32***DY*60~ (EB10 = Lifetime Base Days)
EB*K**30*MA**33***DY*58~ (EB10 = Lifetime Remaining Days)
EB*K**30*MA**7*778~ (2022 Copayment Amt per Day)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

Lifetime Psychiatric Limitation Days

EB*K**A7*MA**32***DY*190~ (EB10=Lifetime Psychiatric Base Days)
EB*K**A7*MA**33***DY*180~ (EB10=Lifetime Psychiatric Remaining Days)

For additional information, refer to Table 30 and Table 31.

7.9 Home Health Periods Business Rules

- Home Health information for all periods that overlap the requested date(s) will only be returned on the 271 response when STC “42” is sent within a 270 request.
- The DTP03 dates associated with DTP01 = “472” are the Home Health period Start and End Date(s).
- The DTP03 dates associated with DTP01 = “193” and “194” are the Home Health period DOEBA and DOLBA.
- When EB13 = “HC|G0180”, the DTP03 date associated with DTP01 = “193” is the Home Health period Certification Date.
- When EB13 = “HC|G0179”, the DTP03 date associated with DTP01 = “193” is the Home Health period Recertification Date.
- If available, the 271 Home Health response includes an MSG segment that contains the Home Health patient status code. The MSG segment includes both the Home Health patient status code and its description. If there is no patient status code on file, then the MSG segment will not be returned.
- If available, the 271 Home Health response includes an MSG segment that contains the Home Health Notice of Admissions (NOA) indicator. Home Health providers use the NOA Indicator to determine if the Medicare beneficiary was transferred from another facility. The MSG segment includes the NOA label and NOA indicator. The description of each NOA indicator is listed below. If there is no NOA indicator on the file, then the MSG segment will not be returned.

Table 12. NOA Indicator Values

NOA Indicator Value	NOA Indicator Meaning
1	NOA received without condition code 47
2	NOA received with condition code 47

- Home Health NPI return in the 2120C Loop NM109 element. The HETS 270/271 application will use multiple loops to return both the Contractor ID and the Provider ID.
- If a Contractor name is unavailable, HETS returns the Contract Number alone without the Contractor name.
- Example segments returned in a 271 response:

  Home Health Benefit Data if beneficiary is Medicare entitled

  EB*X**42***26~ (EB03 = Home Health Care)
  DTP*472*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Home Health Start and End Dates)
  DTP*193*D8*CCYYMMDD~ (DTP03 = DOEBA)
  DTP*194*D8*CCYYMMDD~ (DTP03 = DOLBA)
  MSG*<PatientStatusCode> - <PatientStatusCodeText>
  MSG*NOA - <NOA Indicator>
  LS*2120~
  NM1*PR*2*MAC*****PI*12345~ (NM103=Contractor Name[2]; NM109 = Contractor Number)
  NM1*1P*1******XX*1234567893~ (NM109 = Provider NPI)
  LE*2120~
  EB*X**********HC|G0180~
  DTP*193*D8*CCYYMMDD~ (Home Health Certification Start Date)
  EB*X**********HC|G0179~
  DTP*193*D8*CCYYMMDD~ (Home Health Recertification Start Date)

For additional information, refer to Table 32.

[2] If Contractor Name is unavailable, NM103 is not returned.

7.10 Preventive Care Business Rules

Eligibility/Benefit for Medicare Advantage (MA)
Questions regarding eligibility, coverage, and payment for Medicare Advantage (MA) should be directed to the appropriate MA plan(s) identified in the eligibility response. Each MA plan can have different out-of-pocket costs and specific rules for getting and billing services. You must follow the MA plan's terms and conditions for payment.

- Preventive services are described by the Healthcare Common Procedure Coding System (HCPCS) codes. Although there are many HCPCS codes for which Medicare provides payment, the HETS 270/271 application supports a limited list of preventive HCPCS codes for benefit information. If a Medicare provider includes any of these codes on a 270 eligibility request and all other submitted data matches and is formatted correctly, HETS will return additional benefit information in the 271 eligibility response.
- Preventive care information displays current date information only. No inference about historical eligibility can be made based on the returned next eligible dates. The next eligible date is the date on which the Medicare beneficiary is eligible to receive services specified by the HCPCS.
- Preventive services returned on the HETS 271 response comply with all existing Medicare coverage policy rules. If HETS does not return preventive eligibility data for a specific code, please review Medicare coverage information for that specific code to ensure that the Medicare beneficiary meets all coverage criteria.
- The HETS 270/271 application ignores any procedure modifier value in EQ02-3 of the 2110C loop when received on a 270 request.
- Eligibility for preventive services returns in individual 2110C loops within a 271 response when supported HCPCS codes are submitted for a Medicare beneficiary that has active Part B entitlement and does not have a Date of Death on file at the time of the 270 request.
- Refer to Section 7.7.2 for details about Medicare Part B financial data that may be returned for Preventive services.
- HETS returns two different types of benefit information for preventive services. Those two different types of preventive service benefit responses are outlined in the following two sub-sections.

7.10.1 Preventive HCPCS Codes Which Return Next Eligible Dates

- When applicable, the following HCPCS codes will return a next eligible date for services – that is, the date on which the Medicare beneficiary is eligible to receive services specified by the HCPCS. The next eligible date may be a future date (meaning the service cannot be rendered at this time) or might be a historic date and therefore the Medicare beneficiary is currently eligible for this service.

Preventive care information displays current date information only. No inference about historical eligibility can be made based on the returned next eligible dates.

- Annual Alcohol Misuse Screening includes code G0442 and G0443.
- Annual Depression Screening includes code G0444.
- Annual Wellness Visit (AWV) includes codes G0438 and G0439.
- Cardiovascular Disease Screening (CARD) includes codes 80061, 82465, 83718, and 84478.
- Colorectal Cancer Screening (COLO) includes codes 81528, G0104, G0105, G0106, G0120, G0121, and G0327.
- Computed Tomography Bone Mineral Density Study includes code 77078.
- Computed Tomography, thorax, low dose for lung cancer screening, without contrast material(s) includes code 71271.
- Diabetes Screening Tests (DIAB) includes codes 82947, 82950, and 82951.
- Dual Energy X-ray Absorptiometry (DXA) Bone Density Study; axial skeleton includes code 77080.
- DXA Bone Density Study; appendicular skeleton includes code 77081.
- Fecal Occult Blood Test (FOBT) includes codes G0328 and 82270.
- Glaucoma Screening (GLAU) includes codes G0117 and G0118.
- Hepatitis B Virus (HBV) in Adults Screening includes code G0499.
- Hepatitis C Virus (HCV) in Adults Screening includes code G0472.
- Human Immunodeficiency Virus (HIV) Infection Screening includes code G0475.
- Human Papillomavirus (HPV) for Cervical Cancer Screening includes code G0476.
- Intensive Behavioral Counseling for Obesity includes code G0447 and G0473.
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD) includes code G0446.
- Initial Preventive Physical Examination[3] (IPPE) includes codes G0402, G0403, G0404, and G0405.
- Prostate Cancer Screening (PROS) includes codes G0102 and G0103.

[3] 271 responses for IPPE HCPCS codes may, in certain circumstances, return a 271 2110C EB loop indicating that the Medicare beneficiary is ineligible for this service.

- Screening and Highly Intensive Behavioral Counseling (HIBC) to prevent STIs includes code G0445.
- Screening Mammography (MAMM) includes codes 77067.
- Screening Pap Test (PAPT) includes codes Q0091, P3000, G0123, G0143, G0144, G0145, G0147, and G0148.
- Screening Pelvic Exam (PCBE) includes code G0101.
- Single Energy X-ray Study includes code G0130.
- Ultrasound Bone Density Measurement and Interpretation includes code 76977.
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) includes code 76706.

- If the technical and professional components of a HCPCS code have different next eligible dates, then the 271 response returns a separate 2110C loop for each date.
- Example segments returned in a 271 response for HCPCS codes with a next eligible date:

  Preventive Care with the same Professional and Technical date

  EB*D***MB*********HC|G0121~ (EB13-2 = HCPCS Code)
  DTP*348*D8*CCYYMMDD~ (DTP03 = Next Eligible Date)

  Preventive Care with different Professional and Technical dates for the HCPCS codes and Modifiers

  EB*D***MB*********HC|G0103|26~ (EB13-2 = HCPCS Code, EB13-3 = HCPCS Modifier)
  DTP*348*D8*20150701~ (DTP03 = Next Eligible Professional Date)
  EB*D***MB*********HC|G0103|TC~ (EB13-2 = HCPCS Code, EB13-3 = HCPCS Modifier)
  DTP*348*D8*20150601~ (DTP03 = Next Eligible Technical Date)

For additional information, refer to Table 33.

7.10.2 Preventive HCPCS Codes Which Return Prior Service History

- Prior service history for the following preventive service HCPCS codes returns in individual 2110C loops within a 271 response when supported HCPCS codes are submitted for a Medicare beneficiary that has active Part B entitlement and does not have a Date of Death on file at the time of the 270 request. When applicable and data is available, the following HCPCS codes will return prior service history for the Medicare beneficiary. HETS will return up to ten historical date(s) of service and rendering NPI for prior delivery of these services for each relevant HCPCS code, as necessary.
  - Pneumococcal Vaccine (PPV) includes codes 90670, 90671, 90677, and 90732.

- PPV services delivered to beneficiaries while they are in a Medicare Advantage plan will not be included in the HETS 271 response.
- Example segments returned in a 271 response for HCPCS codes which return prior service history:

EB*D***MB*********HC|90670~ (EB13-2 = PPV HCPCS Code 90670)
DTP*472*D8*20201105~ (DTP03 = Date of Service for HCPCS Code 90670)
LS*2120~
NM1*1P*2******XX*1234567893~ (NM109 = rendering NPI for HCPCS 90670)
LE*2120~
EB*D***MB*********HC|90671~ (EB13-2 = PPV HCPCS Code 90671)
DTP*472*D8*20211105~ (DTP03 = Date of Service for HCPCS Code 90671)
LS*2120~
NM1*1P*2******XX*1234567893~ (NM109 = rendering NPI for HCPCS 90671)
LE*2120~
EB*D***MB*********HC|90677~ (EB13-2 = PPV HCPCS Code 90677)
DTP*472*D8*20210105~ (DTP03 = Date of Service for HCPCS Code 90677)
LS*2120~
NM1*1P*2******XX*1987654323~ (NM109 = rendering NPI for HCPCS 90670)
LE*2120~
EB*D***MB*********HC|90732~ (EB13-2 = PPV HCPCS Code 90732)
DTP*472*D8*20200105~ (DTP03 = Most Recent Date of Service for HCPCS Code 90732)
LS*2120~
NM1*1P*2******XX*1234567893~ (NM109 = rendering NPI for HCPCS 90732)
LE*2120~
EB*D***MB*********HC|90732~ (EB13-2 = PPV HCPCS Code 90732)
DTP*472*D8*20190105~ (DTP03 = Second Most Recent Date of Service for HCPCS Code 90732)
LS*2120~
NM1*1P*2******XX*1987654323~ (NM109 = rendering NPI for HCPCS 90732)
LE*2120~

For additional information, refer to Table 33.

7.11 Smoking/Tobacco Cessation Counseling Business Rules

- Eligibility for smoking/tobacco cessation counseling benefits return within a 271 response when STC “67” is submitted for a Medicare beneficiary that has active Part B entitlement and does not have a Date of Death on file at the time of the 270 request.

- The 271 response returns both the base number and the number of remaining smoking/tobacco cessation counseling sessions. If any counseling sessions have been used in the last 12 months (based on the HETS 270/271 system date), the initial cessation session date of the period will also be returned. Any previous smoking/tobacco cessation periods will not be returned. No next eligible date will be returned, but Medicare Providers can interpret the presence of a smoking/tobacco cessation initial session date within the last 12 months to determine Medicare beneficiary eligibility.
- Example segments returned in a 271 response:

  No Prior Smoking/Tobacco Cessation Counseling Usage within 12 Months

  EB*F**67*MB**22***VS*8~ (EB10 = Smoking Cessation Base Sessions)
  HSD*VS*8***29~ (HSD02 = Smoking Cessation Remaining Sessions)

  OR

  Prior Smoking/Tobacco Cessation Counseling Usage within 12 Months

  EB*F**67*MB**22***VS*8~ (EB10 = Smoking Cessation Base Sessions)
  HSD*VS*3***29~ (HSD02 = Smoking Cessation Remaining Sessions)
  DTP*292*D8*20180501~ (DTP03 = Smoking Cessation Initial Session Date)

For additional information, refer to Table 34.

7.12 Therapy Services Business Rules

- The dollar amount used by the Medicare beneficiary for therapy services returns for all years within the requested Date(s) of Service, when the Medicare beneficiary was also entitled to Part B at any time during those year(s) and when STC “AD”, “AE” and/or “AF” is sent within a 270 request.
- The 271 response will not return Therapy service information when:
  - The Medicare beneficiary was deceased prior to the start of that year.
  - The Medicare beneficiary had an inactive period of Part B entitlement that spanned the entire calendar year.
- The 271 response returns the coverage status for AE and AF if either AE or AF is sent within a 270 request except when the requested Date(s) of Service start date is after the Date of Death or if the Medicare beneficiary is ineligible.
- The 271 response returns EB03 = “AE” to represent a combined usage for Physical and Speech Therapy.
- Example segments returned in a 271 response:

  Therapy Services

  EB*D**AD*MB***200~ (EB03 = AD for Occupational Therapy, EB07 = $200 Therapy Amount Used)
  DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (Calendar Year)
  MSG*Used Amount~

EB*D**AE*MB***500~ (EB03 = AE for Physical/Speech Therapy, EB07 = $500 Therapy Amount Used)
DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (Calendar Year)
MSG*Used Amount~

For additional information, refer to Table 35.

7.13 Pulmonary Rehabilitation Services Business Rules

- The 271 response returns eligibility for Pulmonary Rehabilitation (PR) services when the data is available and STC “BF” is submitted for a Medicare beneficiary that has active Part B entitlement at the time of the 270 request. Professional and/or Technical Sessions Remaining may be returned.
- Example segments returned in a 271 response:

Pulmonary Rehabilitation Services

EB*F**BF*MB**29***CA*72~ (EB10 = PR Sessions Remaining)
MSG*Technical~
EB*F**BF*MB**29***CA*72~ (EB10 = PR Sessions Remaining)
MSG*Professional~

For additional information, refer to Table 36.

7.14 Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Services Business Rules

- The 271 response returns eligibility for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) services when the data is available and STC “BG” is submitted for a Medicare beneficiary that has active Part B entitlement at the time of the 270 request. Professional and/or Technical Sessions Used may be returned.
- Example segments returned in a 271 response:

Cardiac Rehabilitation Services

EB*F**BG*MB*****99*72~ (EB10 = CR Sessions Used)
MSG*Technical~
EB*F**BG*MB*****99*72~ (EB10 = CR Sessions Used)
MSG*Professional~

Intensive Cardiac Rehabilitation Services

EB*F**BG*MB*****99*72~ (EB10 = ICR Sessions Used)
MSG*Intensive Cardiac Rehabilitation - Technical~
EB*F**BG*MB*****99*72~ (EB10 = ICR Sessions Used)
MSG*Intensive Cardiac Rehabilitation - Professional~

For additional information, refer to Table 37 and Table 38.

7.15 End Stage Renal Disease (ESRD) Periods Business Rules

- STC “CQ” or “RN” must be sent within a 270 request to receive ESRD dialysis coverage status and benefit information in a 271 response.
- The HETS 271 response will only return ESRD Coverage Period(s) that overlap with the Date(s) of Service submitted on the 270 request. If the returned ESRD Coverage Period(s) include ESRD Clinical Dialysis and/or ESRD Transplant Effective Date(s), then the HETS 271 response will also return that information. ESRD Clinical Dialysis and Transplant data may be historically limited (i.e., only going back six years or similar).
- The HETS 271 response for ESRD Coverage Period(s) includes the ESRD Coverage Period(s) effective date and, when applicable, also includes the following:
    - ESRD Coverage Period End Date
    - ESRD Clinical Dialysis Start Date
    - ESRD Clinical Dialysis End Date
    - ESRD Transplant Effective Date
- The HETS 271 response for ESRD coverage does not include dialysis method code or method start date.
- Example segments returned in a 271 response:

  ESRD coverage with no ESRD End Date

  EB*D**RN~ (ESRD Benefit Information)
  DTP*292*D8*CCYYMMDD~ (DTP01 ‘292’ = ESRD Coverage Period DTP03 = ESRD Coverage Start date only)

  ESRD coverage with an ESRD End Date

  EB*D**RN~ (ESRD Benefit Information)
  DTP*292*RD8*CCYYMMDD-CCYYMMDD)~ (DTP01 ‘292’ = ESRD Coverage Period DTP03 = ESRD Coverage Start and End dates)

  ESRD coverage with ESRD Clinical Dialysis Start and End dates

  EB*D**RN~ (ESRD Benefit Information)
  DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP01 ‘292’ = ESRD Coverage Period DTP03 = ESRD Coverage Start and End dates)
  DTP*472*RD8*CCYYMMDD-CCYYMMDD~ (DTP01 ‘472’ = ESRD Dialysis DTP03 = ESRD Clinical Dialysis dates – this example includes both ESRD Clinical Dialysis Start and End dates)

  ESRD coverage with ESRD Clinical Dialysis Start and End dates plus ESRD Transplant Effective date

  EB*D**RN~ (ESRD Benefit Information)
  DTP*292*RD8*CCYYMMDD-CCYYMMDD)~ (DTP01 ‘292’ = ESRD Coverage Period DTP03 = ESRD Coverage Start and End dates)

DTP*472*RD8*CCYYMMDD-CCYYMMDD~ (DTP01 ‘472’ = ESRD Dialysis DTP03 = ESRD Clinical Dialysis dates – this example includes both ESRD Clinical Dialysis Start and End dates
DTP*096*D8*CCYYMMDD~ (DTP01 ‘096’ = ESRD Transplant DTP03 = Transplant Effective date

For additional information, refer to Table 39.

7.16 Hospice Care Periods Business Rules

- The Hospice section provides eligibility information when the Hospice benefit is effective and, when applicable, when the Hospice period terminates. When Hospice coverage is elected, the Medicare beneficiary waives all rights to Medicare payments for services that are related to the treatment and management of their terminal illness during any period their Hospice benefit election is in effect, unless the services are provided by the designated Hospice or provided by another Hospice under arrangements made by the designated Hospice. The one exception is for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated Hospice provider, they may not receive compensation from the Hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the Hospice.
- The 271 response returns Hospice information when:
    - STC 45 is sent within the 270 request and
    - The Medicare beneficiary is Part A entitled for at least one day within the date(s) requested on the 270.
- The 271 Hospice response includes Hospice benefit periods and/or Notices of Election (NOE) that appear on the Medicare beneficiary’s file, regardless of the Date(s) of Service submitted on the 270 request. The 271 Hospice response includes all available Hospice Election (NOE) period and Hospice benefit period data (up to a maximum of fifty billed Hospice benefit periods). If there are more than fifty billed Hospice benefit periods, then HETS will return the fifty most recent billed Hospice benefit periods. Hospice providers should utilize the returned Hospice benefit periods and/or Elections to determine Hospice status.
- The 271 Hospice response may include the following elements:

  Hospice Election (NOE)

    - Hospice Election Date
    - Hospice Election Receipt Date
    - Hospice Election Revocation Date
    - Hospice Election Revocation Indicator
    - Hospice Election NPI

Hospice Benefit Period

- Hospice Benefit Period Days Used
- Hospice Benefit Period Effective Date
- Hospice Benefit Period Termination Date
- Hospice Benefit Period Date of Earliest Billing Activity (DOEBA)
- Hospice Benefit Period Date of Latest Billing Activity (DOLBA)
- Hospice Benefit Period NPI

- The 271 response returns Revocation Codes in an MSG segment for each Hospice Election; this value utilizes the Revocation Code from the Election. Revocation Code values returned by the HETS 270/271 application are:

  Medicare beneficiary in Hospice Care

  "0" – Not revoked, open spell

  Medicare beneficiary with Hospice Care Revoked

  "1" – Revoked by notice of revocation
  "2" – Revoked by notice of revocation with a non-payment code of "N" and an occurrence code of "42"
  "3" – Revoked by a Hospice claim with an occurrence code of "23"

- The HETS 271 response typically includes the NPI number of the Hospice facility. There are a limited number of historic Hospice records that do not contain a valid rendering facility NPI number; HETS does not return a rendering Hospice NPI for these very limited cases.

- Example segments returned in a 271 response:

  Hospice Care with one NOE and three Hospice Benefit Periods

  EB*X**45*MA**26~
  DTP*292*D8*20220301~ (DTP03 = Election Date)
  DTP*318*D8*20220323~ (DTP03 = Election Receipt Date)
  DTP*349*D8*20220713~ (DTP03 = Election Revocation Date)
  MSG*Revocation Code – 1~ (Election Revocation Code)
  LS*2120~
  NM1*1P*2******XX*1234567893~ (NM109 = Election NPI)
  LE*2120~
  EB*X**45*MA**26~
  HSD*DY*45~ (Hospice days used in this billed Hospice Benefit Period)
  DTP*292*RD8*20220530-20220713~ (DTP03 = Hospice Benefit Period Effective Date & Termination Date)
  DTP*435*RD8*20220530-20220713~ (DTP03 = Hospice Benefit Period DOEBA-DOLBA)
  LS*2120~
  NM1*1P*2******XX*1649726464~ (NM109 = Hospice Benefit Period NPI)

LE*2120~
EB*X**45*MA**26~
HSD*DY*20~ (Hospice days used in this billed Hospice Benefit Period)
DTP*292*RD8*20220501-20220520~ (DTP03 = Hospice Benefit Period Effective Date & Termination Date)
DTP*435*RD8*20220501-20220520~ (DTP03 = Hospice Benefit Period DOEBA-DOLBA)
LS*2120~
NM1*1P*2******XX*1649726464~ (NM109 = Hospice Benefit Period NPI)
LE*2120~
EB*X**45*MA**26~
HSD*DY*30~ (Hospice days used in this billed Hospice Benefit Period)
DTP*292*RD8*20220301-20220330~ (DTP03 = Hospice Benefit Period Effective Date & Termination Date)
DTP*435*RD8*20220301-20220330~ (DTP03 = Hospice Benefit Period DOEBA-DOLBA)
LS*2120~
NM1*1P*2******XX*1649726464~ (NM109 = Hospice Benefit Period NPI)
LE*2120~

For additional information, refer to Table 40.

7.17 Blood Deductible Business Rules

- The base number of units for which the Medicare beneficiary is liable per year and the number of units remaining for the annual blood deductible return for all years within the requested Date(s) of Service, when the Medicare beneficiary was entitled to either Medicare Part A or Part B at any time during those year(s) and when STC “10” is sent within a 270 request.
- Annual blood deductible does not return when:
    - The Medicare beneficiary was deceased prior to the start of that year.
    - The Medicare beneficiary had an inactive period that spanned the entire calendar year.
- Example segments returned in a 271 response:

    Blood Deductible

    EB*E**10***23***DB*3~ (EB10 = Units Excluded)
    HSD*FL*2***29~ (HSD02 = Units Remaining)
    DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Calendar Year)

For additional information, refer to Table 41.

7.18 Part D Plan Enrollment Business Rules

- All Medicare Part D plans with enrollment periods that overlap the requested date(s) of service return within the 271 response.

- Trading Partners are advised to contact the plans if there are any questions about the plan terms and conditions. In addition, indication of coverage does not imply or guarantee payment by the plan. Trading Partners should contact the plan for full benefit and billing information.
- For information on how to contact plans go to http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html and choose “PDP Plan Directory.”
- MA plans that offer Prescription Drug Coverage as a part of an HMO, PPO, POS, or Indemnity plan return twice – once with the “OT” designation to indicate Prescription Drug Coverage and once with the appropriate qualifiers for their MA Plan Type.
- MA plans that only offer Prescription Drug Coverage return once, with the “OT” designation.
- Example segments returned in a 271 response:

  Part D Coverage Status

  EB*1**88~

  Part D Enrollment

  EB*R**88*OT~ (EB04 = OT – Prescription Drug Coverage)
  REF*18*S12345~ (REF02 = Contract Number)
  REF*N6*001*PLANNAME~ (REF02 = Plan Number, REF03 = Plan Name)
  DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Part D Enrollment and Disenrollment Dates)
  LS*2120~
  NM1*PR*2*ABC DRUG COMPANY~ (NM103 = Contract Name)
  N3*PO BOX 123~ (N301 = Contract Street Address)
  N4*ANYTOWN*MD*999999999~ (N401 = Contract City, N402 = Contract State, N403 = Contract Zip)
  PER*IC**TE*8001234567*UR*www.plan.com~ (PER04 = Plan Telephone Number, PER06 = Contract Website Address)
  LE*2120~

For additional information, refer to Table 24 and Table 42.

7.19 MA Plan Enrollment Business Rules

Eligibility/Benefit for Medicare Advantage (MA)
Questions regarding eligibility, coverage, and payment for Medicare Advantage (MA) should be directed to the appropriate MA plan(s) identified in the eligibility response. Each MA plan can have different out-of-pocket costs and specific rules for getting and billing services. You must follow the MA plan’s terms and conditions for payment.

- All Medicare beneficiary MA plans with enrollment periods that overlap the requested date(s) of service return within the 271 response.
- The 271 response returns one of the following qualifiers within element EB04 in the 2110C loop for each MA enrollment:
    - HM for Health Maintenance Organization (HMO) Medicare Non-Risk
    - HN for HMO Medicare Risk
    - IN for Indemnity
    - PR for Preferred Provider Organization (PPO)
    - PS for Point of Service (POS)
- The 271 response returns only the most recent plan designation (HMO, Indemnity, PPO, POS) for an MA contract, even if the contract's plan designation has changed since the Medicare beneficiary originally enrolled in the contract.
- MA Bill Option Code returns for Insurance Type Code values “HM”, “HN”, “IN”, “PR” and “PS.” The MA Bill Option Codes returned in the 271 response are:

  Medicare beneficiary “locked in” to MA
  “A” – Fiscal Intermediary should process all claims
  “B” – MA should process only in-plan Part A claims and in-area Part B claims
  “C” – MA should process all claims

  Medicare beneficiary NOT “locked in” to MA
  “1” – Fiscal Intermediary should process all claims
  “2” – MA should process only in-plan Part A claims and in-area Part B claims
- The 271 response returns a 271 2110C EB01 value of “U” when the beneficiary is enrolled in an MA plan. While HETS does return basic MA plan information, CMS strongly recommends that Medicare Providers/Suppliers contact the MA plan directly to confirm the beneficiary’s MA plan eligibility information. In addition, indication of coverage does not imply or guarantee payment by the plan.
- The 271 response returns a 271 2110C EB03 value of “30^CQ” when the beneficiary is enrolled in a MA plan and STC ''CQ” was included on the 270 request.
- For information on how to contact plans, go to http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html and choose “MA Plan Directory.”
- MA plans that offer Prescription Drug Coverage as a part of an HMO, PPO, POS, or Indemnity plan return twice – once with the “OT” designation to indicate Prescription Drug Coverage and once with the appropriate qualifiers for their MA Plan Type.
- Example segments returned in a 271 response:

MA

EB*U**30*HN~ (EB04 = Plan Type)
REF*18*H1234~ (REF02 = Contract Number)
REF*N6*001*PLANNAME~ (REF02 = Plan Number, REF03 = Plan Name)
DTP*290*D8*CCYYMMDD~ (DTP03 = MA Enrollment Date)
MSG*MA Bill Option Code – C~
LS*2120~
NM1*PRP*2*ABC HEALTHCARE~ (NM103 = Contract Name)
N3*PO BOX 123~ (N301 = Contract Street Address)
N4*ANYTOWN*MD*999999999~ (N401 = Contract City, N402 = Contract State, N403 = Contract Zip)
PER*IC**TE*8001234567*UR*www.plan.com~ (PER04 = Plan Telephone Number, PER06 = Contract Website Address)
LE*2120~

For additional information, refer to Table 43.

7.20 Medicare Secondary Payer (MSP) Enrollment Business Rules

- The 271 response returns all Medicare beneficiary insurance coverage policies that are primary to Medicare coverage, if the enrollment period overlaps the requested date(s) of service.
- If applicable, all MSP diagnosis codes related to each Medicare beneficiary MSP enrollment period(s) return in the 271 response. The 271 response returns one MSG segment for each applicable MSP enrollment; the MSG segment for diagnosis codes includes all MSP diagnosis codes related to the specific MSP enrollment period. The 271 response may return multiple MSG segments with diagnosis codes if the Medicare beneficiary has multiple applicable MSP enrollment periods. The 271 response only returns ICD-10 codes. The 271 response will not return MSP diagnosis codes that are known to be invalid.
- The 271 MSP response may include the following elements. If data is not available, the MSP segment will not be returned:

  MSP Data

  - MSP Insurance Type Code
  - MSP Policy Number
  - MSP Insurance Group Number or Date of Loss[4]

[4] The HETS 271 MSP response with REF01 equal to '6P' will include either the MSP Insurance Group Number or the MSP Date of Loss. If the returned value is a series of zeroes, this indicates that while there is an MSP enrollment record in CWF, the CWF record does not include the actual MSP Insurance Group Number. If the returned value begins with the acronym 'DOL' (Date of Loss) then the subsequent value is the Date of Loss. DOL is the date of accident or the earlier of the date that treatment for any manifestation of the cumulative injury began, when such treatment preceded formal diagnosis, or the first date that formal diagnosis was made by a medical practitioner.

- MSP Enrollment Date(s)
- MSP Last Maintenance Date
- MSP Ongoing Responsibility for Medicals (ORM) Indicator[5]
- MSP Diagnosis Codes
- MSP Source Code (and text value)
- MSP Patient Relationship Code (and text value)
- MSP Plan Address Information

- Example segments returned in a 271 MSP response:

EB*R**30*14~ (EB04 = MSP Insurance Type Code)
REF*IG*355877442~ (REF02 = MSP Policy Number)
REF*6P*721029~ (REF02 = MSP Group Number or DOL)
DTP*290*D8*20230211~ (Ongoing MSP enrollment period)
DTP*636*D8*20230410~ (DTP03 = MSP last maintenance date)
MSG*ORM – Y~ (ORM Indicator Value)
MSG*M545,M542,M25512,M25412,S40012A,G5622~ (MSP diagnosis codes)
MSG*Source Code- 22-11122-MIR Non-Group Health Plan~ (MSG01 = MSP Source Code & text value)
MSG*Patient Relationship- 01-Patient is insured~ (MSG01 = MSP Patient Relationship Code & text value)
LS*2120~
NM1*PRP*2*XYZ HEALTHPLAN~
N3*987 BROADWAY~
N4*ANYTOWN*HI*999999999~
LE*2120~
EB*R**30*47~ (EB04 = MSP Insurance Type Code)
REF*IG* 21-3915209~ (REF02 = MSP Policy Number)
REF*6P* DOL - 08242021~ (REF02 = MSP Group Number or DOL)
DTP*290*RD8* 20200107-20220107~ (DTP03 = Completed MSP enrollment period)
DTP*636*D8* 20220818~ (DTP03 = MSP last maintenance date)
MSG* S6990XA~ (MSP diagnosis code)
MSG*Source Code- 5-11105-Employer Voluntary Reporting~ (MSG01 = MSP Source Code & text value)
MSG*Patient Relationship- 01-Patient is insured~ (MSG01 = MSP Patient Relationship Code & text value)
LS*2120~
NM1*PRP*2*ABC HEALTHPLAN~
N3*123 MAIN ST~

[5] Providers should utilize the ORM indicator, and the MSP case dates to make their billing determination when MSP Insurance Type Code is 14, 15, 47 or WC. Additional information about MSP ORM is available at CMS.gov.

N4*ANYTOWN*MD*21204~
LE*2120~

For additional information, refer to Table 44.

7.21 Qualified Medicare Beneficiary (QMB) Period Business Rules

- The 271 response returns a 2110C loop for applicable beneficiaries to indicate periods where the beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program. QMB-enrolled beneficiaries are dually eligible for both Medicare and Medicaid. Beneficiaries enrolled in the QMB program are not liable for Medicare co-insurance, co-payments, or deductible payments. Note that QMB status may fluctuate for a minority of beneficiaries. If the HETS response indicates that the beneficiary QMB enrollment has terminated, please verify the patient's QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid Identification cards and documents issued by the State proving the patient qualifies for the QMB program.
- QMB Periods only return in the 271 when the beneficiary has the appropriate Medicare entitlement and the QMB enrollment intersects at least one of the following:
    - One day within a calendar year contained in the request date(s) or unique DOEBA year of any spell being returned.
    - The DOEBA-DOLBA of any spell being returned.
    - The current date.
- The 271 response returns QMB period financials in separate 2110C loop EB segments with EB04 = 'QM' and with unique DTP segment(s) reflecting dates when the beneficiary is enrolled in a QMB period and financial details.
- The 271 response does not return Medicare Part A and Part B Free Services financial 2110C loop EB segments for dates within the calendar year(s) requested when the beneficiary is enrolled in a QMB period.
- The 271 response does not return financial information for preventive HCPCS codes when the beneficiary is dual-eligible for both Medicare and Medicaid (QMB) as of the current system transactions processing date.
- Beneficiaries can be QMB-enrolled at the same time they are enrolled in the Medicare Part B Immunosuppressive Drug Benefit (Part B-ID). In these situations, the 271 would return both the Part B-ID enrollment as well as the QMB enrollment.
- Example QMB segments returned in a 271 response:
    - Example of a QMB Enrollment Period returned in a 271 2110C loop:

        EB*R***QM*State QMB Plan~ (EB05 = State Code + "QMB Plan")
        DTP*290*RD8*CCYYMMDD-CCYYMMDD~ (DTP02 = D8 if the QMB Period is ongoing, RD8 if the QMB period has an end date)

- Example of a QMB Part A Base Deductible Period returned in a 271 2110C loop:

  EB*C**30*QM*Medicare Part A*26*0~
  DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB Part A Hospital Days Base returned in a 271 2110C loop:

  EB*B**30*QM*Medicare Part A*26*0~
  HSD***DA**30*0~
  HSD***DA**31*60~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)
  EB*B**30*QM*Medicare Part A*7*0~
  HSD***DA**30*60~
  HSD***DA**31*90~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB Part A Hospital Days Base as Remaining returned in a 271 2110C loop:

  EB*B**30*QM*Medicare Part A*26*0~
  HSD***DA**29*60~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)
  EB*B**30*QM*Medicare Part A*7*0~
  HSD***DA**29*30~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB Part A Hospital Days Remaining returned in a 271 2110C loop:

  EB*B**30*QM*Medicare Part A*26*0~
  HSD***DA**29*50~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within spell DOEBA/DOLBA when beneficiary is dual eligible for Medicare and Medicaid)
  EB*B**30*QM*Medicare Part A*7*0~
  HSD***DA**29*30~
  HSD*****26*1~

DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within spell DOEBA/DOLBA when beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB SNF Days Base returned in a 271 2110C loop:

  EB*B**AG*QM*Medicare Part A*26*0~
  HSD***DA**30*0~
  HSD***DA**31*20~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)
  EB*B**AG*QM*Medicare Part A*7*0~
  HSD***DA**30*20~
  HSD***DA**31*100~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB SNF Days Base as Remaining returned in a 271 2110C loop:

  EB*B**AG*QM*Medicare Part A*26*0~
  HSD***DA**29*20~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)
  EB*B**AG*QM*Medicare Part A*7*0~
  HSD***DA**29*80~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB SNF Days Remaining returned in a 271 2110C loop:

  EB*B**AG*QM*Medicare Part A*26*0~
  HSD***DA**29*20~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within spell DOEBA/DOLBA when beneficiary is dual eligible for Medicare and Medicaid)
  EB*B**AG*QM*Medicare Part A*7*0~
  HSD***DA**29*80~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within spell DOEBA/DOLBA when beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB Part A Lifetime Reserve returned in a 271 2110C loop:

  EB*K**30*QM*Medicare Part A*7*0~

DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB Part B Base Deductible returned in a 271 2110C loop:

  EB*C**30*QM*Medicare Part B*23*0~
  DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB Part B Coinsurance returned in a 271 2110C loop:

  EB*A**30*QM*Medicare Part B*27*0~
  DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when beneficiary is dual eligible for Medicare and Medicaid)

For additional information, refer to Table 45.

7.22 Medicare Diabetes Prevention Program (MDPP) Business Rules

- HETS 270/271 supports Service Type Code ‘CQ’ (‘Case Management’) in the HETS 270 request. HETS Submitters can utilize the ‘CQ’ STC to request eligibility details for the Medicare Diabetes Prevention Program (MDPP). When this STC is present on the HETS 270 request and all other provided information creates a match, the 271 response includes Medicare beneficiary eligibility, previous MDPP benefit usage (if any) and zero patient financial liability for MDPP services. If applicable to the Medicare beneficiary, the 271 response also returns End Stage Renal Disease (ESRD) information when STC ‘CQ’ is present. The 271 response returns MDPP Eligibility separately from other Part B Covered Services, reflecting only requested dates.
- Active Medicare Part B coverage is required for MDPP eligibility. Medicare beneficiaries that have opted for Medicare Advantage coverage should contact their Medicare Advantage plan for MDPP Coverage Information. Medicare beneficiaries in an active ESRD occurrence are not MDPP eligible.
- HETS 270/271 incorporates the MDPP end date of Period 2 into MDPP service eligibility. If the Medicare beneficiary is ineligible for MDPP services because of their MDPP Period 2 end date, the 271 MDPP response will include an additional DTP segment providing that Period 2 end date.
- If eligible, the 271 response returns HCPCS codes for MDPP services previously rendered for the Medicare beneficiary. Medicare Providers can utilize this historical MDPP usage information to determine the next available MDPP service for a Medicare beneficiary.

  Based on prior MDPP usage, HETS 270/271 can potentially return the following MDPP HCPCS codes on a 271 response:

  - The 271 response returns a single MDPP HCPCS code of G9873 (representing ‘Initiating Payment’) when the Medicare beneficiary has no prior MDPP usage.

- The 271 response returns the MDPP HCPCS code, the Billing Provider NPI and the Date of Service for each utilized MDPP HCPCS code. Potential MDPP HCPCS codes that can be returned as actual usage are G9873, G9874, G9875, G9876, G9877, G9878, G9879, G9880, G9881, G9882, G9883, G9884, G9885, G9890, and G9891.

Based on prior usage, MDPP HCPCS codes G9890 and G9891 can be returned multiple times. All other MDPP HCPCS codes are once-in-a-lifetime services and only return once in a 271 response.

While the 271 response may include the MDPP HCPCS listed above, HETS 270/271 does not support use of these MDPP HCPCS codes on a 270 request. HETS 270/271 will disregard these HCPCS codes if submitted on a 270 request. Submitters requesting prior MDPP usage information on the 271 response should submit STC "CQ."

- The HETS 270/271 application returns a limited eligibility response for MDPP-only suppliers. An NPI's status as a MDPP supplier is determined via the 'D1' specialty code on the NPI record. MDPP suppliers can contact MCARE for additional information regarding this limited eligibility response. The limited eligibility response for MDPP suppliers disregards any non-MDPP related STCs and/or HCPCS codes submitted in the request.
- Example MDPP segments returned in a normal 271 response:
  - MDPP Information for Medicare beneficiary with no prior MDPP usage

    EB*1**CQ*MB~
    DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = MDPP entitlement period)
    EB*C**CQ*MB**23*0~ (EB07 = deductible amount of "0")
    DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = MDPP entitlement period)
    EB*A**CQ*MB**27*0~ (EB07 = coinsurance amount of "0")
    DTP*292*RD8*20180115-20180201~ (DTP03 = MDPP entitlement period)
    EB*1***MB*********HC|G9873~ (HCPCS G9873 represents 'Initiating Payment')

  - MDPP Information for Medicare beneficiary with prior MDPP usage

    EB*1**CQ*MB~
    DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = MDPP entitlement period)
    EB*C**CQ*MB**23*0~ (EB07 = deductible amount of "0")
    DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = MDPP entitlement period)
    EB*A**CQ*MB**27*0~ (EB07 = coinsurance amount of "0")
    DTP*292*RD8*20180115-20180201~ (DTP03 = MDPP entitlement period)

EB*D***MB*********HC|G9873~ (HCPCS G9873 represents ‘Initiating Payment’)
DTP*472*D8*20180605~ (Date of Service)
LS*2120~
NM1*1P*2******XX*1234567893~ (NPI rendering MDPP service)
LE*2120~
EB*D***MB*********HC|G9891~ (different MDPP HCPCS code)
DTP*472*D8*20180720~ (Date of Service)
LS*2120~
NM1*1P*2******XX*1222222223~ (NPI rendering MDPP service)
LE*2120~
EB*D***MB*********HC|G9891~ (HCPCS code G9891 returned multiple times)
DTP*472*D8*20180827~ (Date of Service)
LS*2120~
NM1*1P*2******XX*1111111113~ (Different NPI rendering MDPP service)
LE*2120~
EB*D***MB*********HC|G9874~ (different MDPP HCPCS code)
DTP*472*D8*20180973~ (Date of Service)
LS*2120~
NM1*1P*2******XX*1234567893~ (NPI rendering MDPP service)
LE*2120~

- MDPP Information for Medicare beneficiary with exhausted MDPP eligibility

EB*6**CQ*MB~
DTP*292*RD8*20190901-20190930~ (DTP03 = Requested Dates of Service)
DTP*194*D8*20190501~ (DTP03 = MDPP End Date of Period 2)

For additional information, refer to Table 46.

7.23 Acupuncture Services Business Rules

- Eligibility for acupuncture benefits return within a 271 response when STC “64” is submitted for a Medicare beneficiary that has active Part B entitlement and does not have a Date of Death on file at the time of the 270 request. The 271 response may include the following components:
    - Number of Technical Sessions Remaining
    - Next Technical Date
    - Number of Professional Sessions Remaining
    - Next Professional Date

- No more than twenty acupuncture treatments may be administered in a rolling one year period per CMS guidelines. The rolling one year period is based on the initial date of service. Example: If the first session is performed on March 21, 2022, services in the next service year cannot be performed before March 1, 2023. Eleven full months must pass from the date of the initial service before a new rolling year can begin.
- If the number of sessions remaining equals twenty (‘20’), then the value returned in the 271 2110C DTP03 element equals the next eligible date. If the number of sessions remaining is one through nineteen (‘1’ – ‘19’), then the value returned in the 271 2110C DTP03 element is the first acupuncture session in the current rolling one year period. If the Medicare beneficiary does not have active Medicare Part B entitlement and/or has a Date of Death on file, HETS will return zero (‘0’) sessions remaining and no 271 2110C DTP loop would be returned.
- Example segments returned in a 271 response:

  Acupuncture Services

  EB*F**64*MB**29***CA*19~ (EB10 = Technical Sessions Remaining)
  DTP*472*D8*20210107~ (DTP03 = First Technical Session, current annual period)
  MSG*Technical~
  EB*F**64*MB**29***CA*20~ (EB10 = Professional Sessions Remaining)
  DTP*472*D8*20201110~ (DTP03 = Next Professional Eligible Date)
  MSG*Professional ~

For additional information, refer to Table 47.

7.24 Vaccination Business Rules

Eligibility/Benefit for Medicare Advantage (MA)
Questions regarding eligibility, coverage, and payment for Medicare Advantage (MA) should be directed to the appropriate MA plan(s) identified in the eligibility response. Each MA plan can have different out-of-pocket costs and specific rules for getting and billing services. You must follow the MA plan’s terms and conditions for payment.

- The HETS 270/271 application supports Service Type Codes for COVID-19 and Influenza vaccination in the 270 eligibility request. Each vaccination service requires a unique Service Type Code and returns information separately in the 271 eligibility response.

7.24.1 COVID-19 Vaccination Business Rules

- Prior COVID-19 vaccination services return on a 271 response when STC ‘80’ (Immunizations) is submitted on a valid 270 request for a Medicare beneficiary that has active Part B entitlement **and** does not have a Date of Death on file at the time of the request.

- HETS returns the most recent information for COVID-19 vaccine and/or vaccination administration. The HETS 271 response for COVID-19 vaccination will include the following service components:
    - Applicable Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code(s) for each COVID-19 vaccination (vaccine and/or vaccination administration)
    - Vaccination Date
    - Rendering Medicare Provider NPI Number (when available)
- The HETS 271 response does not include any information about COVID-19 monoclonal antibodies.
- The HETS 271 response for COVID-19 vaccination plan level eligibility typically returns this data via separate 271 2110C EB & DTP loops. These separate DTP loops will return COVID-19 vaccination eligibility based on the current HETS system date only. If applicable, COVID-19 and Influenza (Flu) vaccination plan level eligibility may be returned via combined 271 2110C EB & DTP loops.
- Deductible and coinsurance are not applicable for COVID-19 vaccination; financial liability information for COVID-19 vaccination will only be returned for the current year.
- Example segments returned in a 271 response:

  Vaccination Example 1 - Medicare beneficiary that has received three doses of COVID-19 Vaccine A.

  EB*1**80*MB~ (Indicator the beneficiary is eligible for Vaccination under Part B)
  DTP*771*D8*CCYYMMDD~ (DTP03 = Current HETS system date)
  EB*C**80*MB**23*0~ (EB07 = 0 to display the Part B Base Deductible is not applicable)
  DTP*292*RD8*20220101-20221231~ (Current calendar year)
  EB*A**80*MB**27**0~ (EB07 = 0 to display the Part B Coinsurance is not applicable)
  DTP*292*RD8*20220101-20221231~ (Current calendar year)
  EB*D**********HC|91300~ (EB13-2 = COVID-19 Vaccine Code 91300)
  DTP*472*D8*20210823~ (DTP03 = Third Vaccination Date - 91300)
  LS*2120~
  NM1*1P*2******XX*1234567893~ (NM109 = rendering NPI - 91300)
  LE*2120~
  EB*D**********HC|0003A~ (EB13-2 = Administration Code - 0003A)
  DTP*472*D8*20210823~ (DTP03 = Third Vaccination Date - 0003A)
  LS*2120~
  NM1*1P*2******XX*1234567893~ (NM109 = rendering NPI - 0003A)
  LE*2120~
  EB*D**********HC|0002A~ (EB13-2 = Administration Code - 0002A)
  DTP*472*D8*20210123~ (DTP03 = Second Vaccination Date - 0002A)

LS*2120~
NM1*1P*2******XX*1234567893~ (NM109 = rendering NPI - 0002A)
LE*2120~
EB*D**********HC|0001A~ (EB13-2 = Administration Code - 0001A)
DTP*472*D8*20201221~ (DTP03 = First Vaccination Date - 0001A)
LS*2120~
NM1*1P*2******XX*1987654323~ (NM109 = rendering NPI - 0001A)
LE*2120~

Vaccination Example 2 - Medicare beneficiary that has received two doses of COVID-19 Vaccine B.

EB*1**80*MB~ (Indicator the beneficiary is eligible for Vaccination under Part B)
DTP*771*D8*CCYYMMDD~ (DTP03 = Current HETS system date)
EB*C**80*MB**23*0~ (EB07 = 0 to display the Part B Base Deductible is not applicable)
DTP*292*RD8*20220101-20221231~ (Current calendar year)
EB*A**80*MB**27**0~ (EB07 = 0 to display the Part B Coinsurance is not applicable)
DTP*292*RD8*20220101-20221231~ (Current calendar year)
EB*D**********HC|0012A~ (EB13-2 = Administration Code - 0012A)
DTP*472*D8*20210206~ (DTP03 = Second Vaccination Date - 0012A)
LS*2120~
NM1*1P*2******XX*1234567893~ (NM109 = rendering NPI - 0012A)
LE*2120~
EB*D**********HC|0011A~ (EB13-2 = Administration Code - 0011A)
DTP*472*D8*20210107~ (DTP03 = First Vaccination Date - 0011A)
LS*2120~
NM1*1P*2******XX*1234567893~ (NM109 = rendering NPI - 0011A)
LE*2120~

For additional information, refer to Table 48.

7.24.2 Influenza (Flu) Vaccination Business Rules

- Prior Influenza (Flu) vaccination services return on a 271 response when STC ‘CO’ (Flu Vaccination) is submitted on a valid 270 request for a Medicare beneficiary that has active Part B entitlement and does not have a Date of Death on file at the time of the request.
- HETS returns prior vaccination data for services billed through CMS. Flu vaccinations obtained through Medicare Advantage or public health services will not be included in the HETS 271 response.
- HETS returns all Flu vaccination data for services that were delivered within the last 18 months (based upon the current system date).
- The HETS 271 response for Flu vaccination will include the following service components:

  - Applicable Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code(s) for each Flu vaccination (vaccine and/or vaccination administration)
  - Vaccination Date
  - Rendering Medicare Provider NPI Number (when available)
- The HETS 271 response for Flu vaccination plan level eligibility typically returns this data via separate 271 2110C EB & DTP loops. These separate DTP loops will return Flu vaccination eligibility based on the current HETS system date only. If applicable, Flu and COVID-19 vaccination plan level eligibility may be returned via combined 271 2110C EB & DTP loops.
- Deductible and coinsurance are not applicable for Flu vaccination; financial liability information for Flu vaccination will only be returned for the current year
- The 271 response for each Flu vaccination service will typically include both vaccine and vaccine administration codes for each service.
- Example segments returned in a 271 response:

  EB*1**CO*MB~ (Indicator the beneficiary is eligible for Vaccination under Part B)
  DTP*771*D8*CCYYMMDD~ (DTP03 = Current HETS system date)
  EB*C**CO*MB**23*0~ (EB07 = 0 to display the Part B Base Deductible is not applicable)
  DTP*292*RD8*20220101-20221231~ (Current calendar year)
  EB*A**CO*MB**27**0~ (EB07 = 0 to display the Part B Coinsurance is not applicable)
  DTP*292*RD8*20220101-20221231~ (Current calendar year)
  EB*D**********HC|90630~ (EB13-2 = Flu Vaccine HCPCS Code 90630)
  DTP*472*D8*20210123~ (DTP03 = Corresponding Date of Service for HCPCS Code 90630)
  LS*2120~
  NM1*1P*2******XX*1987654323~ (NM109 = rendering NPI for HCPCS 99483)
  LE*2120~
  EB*D**********HC|G0008~ (EB13-2 = Flu Vaccine Administration HCPCS Code)
  DTP*472*D8*20210123~ (DTP03 = Corresponding Date of Service for HCPCS Code G0008)
  LS*2120~
  NM1*1P*2******XX*1987654323~ (NM109 = rendering NPI for HCPCS G00008)
  LE*2120~

For additional information, refer to Table 48.

7.25 Cognitive Assessment and Care Plan Services Business Rules

- The 271 response returns eligibility for Cognitive Assessment and Care Plan services when the data is available and STC “BD” (Cognitive Therapy) is submitted for a Medicare beneficiary that has active Part B entitlement at the time of the 270 request. HETS will not return this information if the Medicare beneficiary has a recorded Date of Death prior to or equal to the requested Date(s) of Service.
- The 271 response includes all prior Cognitive Assessment and Care Plan services rendered during the requested Date(s) of Service. If there were no services provided during the requested Date(s) of Service, then the 271 includes the most recent service occurrence (if applicable).
- The HETS 271 response for Cognitive Assessment and Care Plan services may include the following components:
    - Prior Cognitive Assessment and Care Plan HCPCS (99483)
    - Date of Service
    - Rendering Provider NPI
- Example segments returned in a 271 response:

    EB*D**********HC|99483~ (EB13-2 = Cognitive HCPCS Code 99483)
    DTP*472*D8*20210123~ (DTP03 = Most Recent Date of Service for HCPCS Code 99483)
    LS*2120~
    NM1*1P*2******XX*1234567893~ (NM109 = rendering NPI for HCPCS 99483)
    LE*2120~
    EB*D**********HC|99483~ (EB13-2 = Cognitive HCPCS Code 99483)
    DTP*472*D8*20190101~ (DTP03 = Second Most Recent Date of Service for HCPCS Code 99483)
    LS*2120~
    NM1*1P*2******XX*1987654323~ (NM109 = rendering NPI for HCPCS 99483)
    LE*2120~

For additional information, refer to Table 49.

7.26 Part B Immunosuppressive Drug Benefit Business Rules

- Medicare began offering the Part B Immunosuppressive Drug Benefit (Part B-ID) in January 2023. Part B-ID helps people with Medicare pay for immunosuppressive drugs beyond 36 months following a kidney transplant, if they do not have other health care coverage. The new benefit only covers immunosuppressive drugs; no other items or services are covered.

- The 271 response indicates Medicare Part B coverage for Part B-ID enrollees when the requested Date(s) of Service include a period where the individual is enrolled in the Part B-ID benefit. The 271 response will return up to ten (10) Part B-ID enrollment periods that intersect with the requested Date(s) of Service. The requested Date(s) of Service must be on or prior to any recorded Date of Death on file.

- If the 270 request Dates of Service includes a range of dates where the Medicare beneficiary was entitled to or enrolled in multiple types of Medicare coverage (e.g., traditional Medicare, Medicare Advantage, Part B-ID) then the 271 response will include specific dates and entitlement/enrollment details for each coverage period.

- The HETS 271 response will include a Medicare Part B enrollment reason in the 271 2110C MSG segment: “MSG*P-Part B Immunosuppressive Drug Benefit~”. See Table 11 for additional information. The HETS 271 response will return Part B-ID coverage as active Medicare Part B enrollment only.

- When Medicare Providers or Suppliers see enrollment reason code ‘P’ it means the individual only has Part B-ID coverage for immunosuppressive drugs. No other Part B services can be rendered or billed for these beneficiaries.

- The 271 response for Part B-ID will indicate active Medicare Part B coverage limited to:

    - Part B-ID Enrollment
    - Part B Financials (Deductible/Coinsurance)

- The 271 response for Part B-ID coverage periods will indicate inactive coverage or, through normal omission, indicate no coverage for the requested Date(s) of Service for the following:

    - Medicare Part A (inactive)
    - Medicare Part D (inactive)

- The HETS 271 response for Part B-ID coverage periods will never include Medicare Advantage (MA) or Medicare Secondary Payer (MSP) data.

- All benefit specific Service Type Codes or HCPCS Codes submitted on the 270 requests will return as inactive benefits on the 271 response when the Medicare beneficiary is enrolled in the Part B-ID program for the requested Date(s) of Service.

- Part B-ID coverage periods can overlap Qualified Medicare Beneficiary (QMB) periods where the individual has state administered Medicaid coverage.

Part B-ID Example 1

Example of a Medicare beneficiary who has active Part B-ID coverage effective 1/1/2023. The beneficiary does not have QMB coverage.

270 Date of Eligibility Request: 12/15/2022

270 Dates of Service: 1/1/2023 – 1/4/2023

270 Requested Service Type Codes: 30 (health benefit plan coverage), RN (Renal)

270 Requested HCPCS Codes: Q0091

271 Date of Eligibility Response: 12/15/2022

271 Dates of Service: 1/1/2023 – 1/4/2023

271 Responded Service Type Codes:

- 30 (health benefit plan coverage) – returns as inactive for Part A, active for Part B due to Part B-ID enrollment.
- RN (Renal) – returns as inactive. Part B-ID only covers immunosuppressive drugs; no other items or services are covered.

271 Requested HCPCS Codes: Q0091 – returns as inactive. Part B-ID only covers immunosuppressive drugs; no other items or services are covered

271 returns Medicare Part A & Medicare Part D as inactive for this Part B-ID beneficiary.

Medicare Part B coinsurance & deductible are applicable and included on the 271 response.

DTP*307*RD8*20230101-20230104~
EB*I**41^54~
EB*6**88~
EB*6**30^RN*MA~
EB*1**30*MB~
DTP*291*D8*20230101~
MSG*P–Part B Immunosuppressive Drug Benefit~
EB*6**2^23^24^25^26^27^28^3^33^36^37^38^39^40^42^50^51^52^53^67^69^73^76^83^86^98^A4^A6^A8^AI^AJ^AK^AL^BT^BU^BV^DM^RN^UC*MB~
EB*C**30*MB**23*226~
DTP*291*RD8*20230101-20231231~
EB*C**30*MB**29*226~
DTP*291*RD8*20230101-20231231~
EB*A**30*MB**27**.2~
DTP*291*RD8*20230101-20231231~
EB*6***MB*********HC|Q0091~

Part B-ID Example 2

Example of a Medicare beneficiary who has active Part B-ID coverage effective 1/1/2023. The beneficiary also has QMB coverage.

270 Date of Eligibility Request: 12/15/2022

270 Dates of Service: 1/1/2023 – 1/4/2023

270 Requested Service Type Codes: 30 (health benefit plan coverage), 81 (routine physical)

270 Requested HCPCS Codes: None

271 Date of Eligibility Response: 12/15/2022

271 Dates of Service: 1/1/2023 – 1/4/2023

271 Responded Service Type Codes:

- 30 (health benefit plan coverage) – returns as inactive for Part A, active for Part B due to Part B-ID enrollment.
- 81 (routine physical) – returns as inactive. Part B-ID only covers immunosuppressive drugs; no other items or services are covered.

271 returns Medicare Part A & Medicare Part D as inactive for this Part B-ID beneficiary.

Medicare Part B coinsurance & deductible are applicable and included on the 271 response.

271 returns QMB coverage via the State of Massachusetts (effective 3/1/2022) and waives Part B deductible and coinsurance.

DTP*307*RD8*20230101-20230104~
EB*I**41^54~
EB*6**88~
EB*R***QM*MA QMB Plan~
DTP*290*D8*20220301~
EB*6**30*MA~
EB*1**30*MB~
DTP*291*D8*20230101~
MSG*P–Part B Immunosuppressive Drug Benefit~
EB*6**2^23^24^25^26^27^28^3^33^36^37^38^39^40^42^50^51^52^53^67^69^73^76^81^83^86^98^A4^A6^A8^AI^AJ^AK^AL^BT^BU^BV^DM^UC*MB~
EB*C**30*QM*Medicare Part B*23*0~
DTP*291*RD8*20230101-20231231~
EB*A**30*QM*Medicare Part B*27**0~
DTP*291*RD8*20230101-20231231~

Part B-ID Example 3

Example of a Medicare beneficiary who has active Part B-ID coverage effective 1/1/2023. The beneficiary also had prior Medicare Part A & B coverage for ESRD – that coverage terminated on 1/31/2022.

270 Date of Eligibility Request: 12/15/2022

270 Dates of Service: 12/1/2021 – 1/4/2023

270 Requested Service Type Codes: 30 (health benefit plan coverage)

271 Date of Eligibility Response: 12/15/2022

271 Dates of Service: 12/1/2022 – 1/4/2023

The Date of Service request includes a period (1/1/2022 – 1/31/2022) when the individual was entitled to Medicare Part A & B for ESRD. The 271 response will show that historic coverage and its termination date. The 271 response will also show active coverage for Part B-ID enrollment beginning 1/1/2023.

For the period 1/1/2022 – 1/31/2022 – the HETS 271 response returns active Part A & B coverage for ESRD.

For the period 2/1/2022 – 12/31/2022 – the HETS 271 response shows no active Medicare coverage.

For the period 1/1/2023 – 1/4/2023 – the HETS 271 response shows active Part B-ID coverage.

DTP*307*RD8*20211201-20230104~
EB*I**41^54~
EB*6**88~
EB*1**30^42^45^48^49^69^76^83^A5^A7^AG^BT^BU^BV*MA~
DTP*291*RD8*20220101-20220131~
MSG*2-Beneficiary insured due to End Stage Renal Disease ESRD~
EB*C**30*MA**26*1556~
DTP*291*RD8*20220101-20221231~
EB*C**30*MA**29*1556~
DTP*291*RD8*20220101-20221231~
EB*C**42^45*MA**26*0~
DTP*292*RD8*20220101-20221231~
EB*1**30*MB~
DTP*291*D8*20230101~
MSG*P–Part B Immunosuppressive Drug Benefit~
EB*1**30^2^23^24^25^26^27^28^3^33^36^37^38^39^40^42^50^51^52^53^67^69^73^76^83^86^98^A4^A6^A8^AI^AJ^AK^AL^BT^BU^BV^DM^UC*MB~
DTP*291*RD8*20220101-20220131~
MSG*2-Beneficiary insured due to End Stage Renal Disease ESRD~
EB*C**30*MB**23*226~
DTP*291*RD8*20230101-20231231~

EB*C**30*MB**23*233~
DTP*291*RD8*20220101-20221231~
EB*C**30*MB**29*226~
DTP*291*RD8*20230101-20231231~
EB*C**30*MB**29*0~
DTP*291*RD8*20220101-20221231~
EB*A**30*MB**27**.2~
DTP*291*RD8*20230101-20231231~
EB*A**30*MB**27**.2~
DTP*291*RD8*20220101-20221231~
EB*C**42^67^AJ*MB**23*0~
DTP*292*RD8*20220101-20221231~
EB*A**42^67^AJ*MB**27**0~
DTP*292*RD8*20220101-20221231~

7.27 Audiology Diagnostic Testing Business Rules

- The HETS 270/271 application supports select audiology diagnostic testing HCPCS codes on the 270 eligibility request. If a Medicare provider includes any of these codes on a 270 eligibility request and all other submitted data matches and is formatted correctly, HETS returns next eligible dates for these select codes in the 271 eligibility response.
- Select audiology diagnostic testing HCPCS Codes that can be submitted on a 270 request are: 92550, 92552, 92553, 92555, 92556, 92557, 92562, 92563, 92565, 92567,92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92601, 92602, 92603, 92604, 92620, 92621, 92625, 92626, 92627, 92640, 92651, 92652, and 92653.
- The HETS 270/271 application ignores any procedure modifier value in EQ02-3 of the 2110C loop when received on a 270 request.
- The HETS 271 only includes audiology service information if the Medicare beneficiary has active Part B entitlement and does not have a recorded Date of Death on file at the time of the 270 request.
- Refer to Section 7.7.2 for details about Medicare Part B financial data that may be returned for audiology diagnostic testing services. Part B financial data for audiology diagnostic testing services would be returned after Part B financial data for preventive services.
- Select audiology diagnostic testing HCPCS codes will return a next eligible date from upstream systems for services – that is, the date on which the Medicare beneficiary is eligible to receive services specified by the HCPCS codes. The next eligible date may be a future date (meaning the service cannot be rendered at this time) or it might be an historic date and therefore the Medicare beneficiary is currently eligible for this service. The HETS 271 response for audiology diagnostic testing displays current date information only. No inference about historical eligibility can be made based on the returned next eligible dates.

- If the technical and professional components of a HCPCS code have different next eligible dates, then the 271 response returns a separate 2110C loop for each date.
- If the audiology diagnostic testing service includes only a professional component, then the 271 detail for that service includes a HCPCS modifier indicating the next eligible date is for professional services only.
- Example segments returned in a 271 response for audiology diagnostic testing HCPCS codes:

  Audiology Diagnostic Testing with Professional component only

  EB*D***MB*********HC|92653|26~ (EB13-2 = HCPCS Code; EB13-3 = HCPCS Modifier)
  DTP*348*D8*CCYYMMDD~ (DTP03 = Next Eligible Date)

  Audiology Diagnostic Testing with different Professional and Technical dates

  EB*D***MB*********HC|92587|26~ (EB13-2 = HCPCS Code, EB13-3 = HCPCS Modifier)
  DTP*348*D8*CCYYMMDD~ (DTP03 = Next Eligible Professional Date)
  EB*D***MB*********HC|92587|TC~ (EB13-2 = HCPCS Code, EB13-3 = HCPCS Modifier)
  DTP*348*D8*CCYYMMDD~ (DTP03 = Next Eligible Technical Date)

Additional information about audiology services is available at CMS.gov. For additional information, refer to Table 33.

8 Acknowledgements and Error Codes

Only one response is sent for each 270 request that is submitted – a TA1, a 999, a 271, or a proprietary error message. There are no CMS reports regarding the 270/271 transactions available to Trading Partners.

8.1 TA1

The TA1 Interchange Acknowledgement is used by the HETS 270/271 application to communicate the rejection of a 270 request based on errors encountered with X12 compliance, formatting, or CMS specific requirements of the ISA/IEA Interchange segments. Following are examples of when a TA1 may return if one of the conditions listed below exists:

- A 270 request is received, and the version of the transmission cannot be determined.
- A 270 request is received, and the version of the transmission is unsupported by the HETS 270/271 application. This includes previously accepted versions that are no longer supported.
- The Trading Partner is not authorized for the submitted X12 version.
- The sender is not authorized as an active HETS 270/271 Trading Partner.

8.2 999

The 999 Implementation Acknowledgement is used by the HETS 270/271 application to communicate the rejection of a 270 request based on errors encountered with X12 compliance, formatting, or CMS specific requirements within the data segments between the Functional Group Header (GS) and Functional Group Trailer (GE). Refer to the ASC X12 999 version 005010X231A1 TR3 for additional information.

8.3 271

When the 270 request complies with the X12 standard syntax requirements and all additional formatting rules as specified by this *Companion Guide*, then a 271 response returns to the Trading Partner. If no error exists, the Medicare beneficiary eligibility data returns within the 271 response. Refer to Section 10.2 of this *Companion Guide* for more information.

The AAA error segment is utilized within the 271 response to communicate error conditions based on CMS business rules. The HETS 270/271 application returns the invalid or non-matching data element(s) from the 270 request for 2100C Loop AAA error codes 58, 62, 71, 72, and 73. The AAA error codes are specified in Table 13.

Table 13. AAA Error Codes

Loop	AAA01 Yes/ No Condition	AAA03 Reject Reason Code	AAA04 Follow-up Action Code
2100A	No	04 – When multiple Medicare beneficiaries are included on a single 270 request.	C
2100A	Yes	42 – When the system is unable to respond.	R
2100A	No	79 – When 270 2100A NM103 or NM109 Source identification is other than “CMS.”	C
2100A	No	T4 – When 270 2100A NM103 or NM109 is missing.	C
2100B	No	41 – When the National Provider Identifier (NPI) located at 2100B NM109 is a valid FFS Medicare NPI and exists in HETS Desktop (HDT), but there is no current, valid relationship between the NPI and the provided HETS Submitter ID. Ensure that there is a relationship between your Submitter ID and the NPI in HETS Desktop (HDT).	C
2100B	No	43 – When the 2100B NM101 is not equal to “1P”, “FA” or “80” or when the NPI located at 2100B NM109 has an invalid Medicare Provider status. If you believe that the NPI is a valid FFS Medicare Provider or supplier, contact your MAC for verification.	C
2100B	No	50 – When the NPI located at 2100B NM109 is a valid, FFS Medicare provider or supplier but is not currently eligible to verify Medicare eligibility in HETS. Contact MCARE for further information.	C
2100B	No	51 – When the NPI located at 2100B NM109 is not on file with HETS. Verify that the NPI is a valid FFS Medicare Provider and ensure that the NPI is added to your Submitter ID via HETS Desktop (HDT). An overnight update may be required before the NPI can be used with HETS.	C
2100C	No	58 – When the 270 2100C DMG02 element and NM104 element are both missing.	C
2100C	No	62 – When the 270 2100C DTP03 element request date is more than 4 years in the past, or more than 4 months in the future from current day.	C
2100C	No	71 – When the 270 2100C DMG02 element does not match the Medicare beneficiary DOB on the database.	C
2100C	No	72 – When the 270 2100C NM109 element is either: • An invalid length or cannot be matched to any MBI on the database, or • Missing. When the NM109 element is missing, the 271 AAA response will also return the value “MISSING” in the 271 2100C NM109	C

Loop	AAA01 Yes/ No Condition	AAA03 Reject Reason Code	AAA04 Follow-up Action Code
2100C	No	73 – When the 270 2100C NM103 element is missing, or the matching algorithm of the Medicare beneficiary last name on the 270 request does not satisfy the matching algorithm of the Medicare beneficiary last name in the database, or the last name is too long (41-60 characters in length).	C
2100C	No	73 – When the 270 2100C NM104 element does not satisfy the matching algorithm of the Medicare beneficiary first name in the database, or the first name is too long (31-35 characters in length).	C

8.4 Proprietary Error Message

Proprietary error messages are sent only when it is impossible to formulate an X12 compliant response. The proprietary message will return error codes and descriptions. Trading Partners may contact MCARE for assistance with proprietary errors. The format for the proprietary messages is described in Table 14.

Table 14. Proprietary Error Message Format

Data Element	Description	Size	Comments
Transaction ID	Transaction ID	4	Data content will be “HETS”
Transaction Reference Number	Trace Identification Number or (ISA13)	30	Spaces
Date/Time Stamp	System Date & Time	17	CCYYMMDDHHMMSSddd
Response Code Indicator	ISA Formatting Error	1	Space
Message Code	Error Code	8	Error code, refer to Table 15 of this *Companion Guide*
Message Text Description	Error Descriptions	500	“Message Text Description”, refer to Table 15 of this *Companion Guide*

Table 15 describes the proprietary error message codes.

Table 15. Proprietary Error Message Codes

Message Code	Message Text Description
HTS00101	Transmission Wrapper SOH (hex = 01) is invalid or missing.
HTS00102	Transmission Wrapper STX (hex = 02) is invalid or missing.
HTS00103	ETX is not in the expected location.

Message Code	Message Text Description
HTS00104	Unexpected System Exception occurred while processing transaction. Please resubmit.
HTS00105	Transmission Wrapper Length invalid, missing or not numeric.
HTS00111	Transmission inbound message was empty.
HTS00158	Submitter ID/Transaction Source Mismatch.
HTS00160	The Transaction Envelope could not be read, please correct, and resubmit.
HTS00201	ISA13 not 9 characters in length.
HTS00203	ISA13 and IEA02 do not match.
HTS00204	ISA13 must be numeric.
HTS00206	ISA13 is missing.
HTS00207	IEA02 is missing.
HTS00208	IEA02 not 9 characters in length.
HTS00210	IEA02 must be numeric.
HTS00250	Certificate not valid for Submitter ID.

8.5 Common Error Processing for SOAP+WSDL and HTTP MIME/Multipart

The HETS 270/271 application processes SOAP and MIME transactions and returns errors as described in this section.

8.5.1 HTTP Status and Error Codes

The processing and error codes for the HTTP layer are defined as part of the HTTP specifications: http://www.w3.org/Protocols/rfc2616/rfc2616-sec10.html. The intended use of these status and error codes in processing transactions is specified in Table 4.3.3.1 of the Phase II CORE 270: Connectivity Rule referenced in Section 4.3.3.3.

8.5.2 Envelope Processing Status and Error Codes

Table 16 describes envelope processing status and error codes specific to the HETS 270/271 application for SOAP and MIME transactions.

Table 16. Envelope Processing Status and Errors

Error Code	Error Message
<FieldName>Illegal	Illegal value provided for <FieldName>.
<FieldName>Required	The field <FieldName> is required but was not provided.
VersionMismatch	The CORERuleVersion sent is not acceptable to the Receiver.
Success	Envelope was processed successfully.

8.5.4 SOAP-Specific Processing Errors

Table 17 describes examples of SOAP processing errors.

Table 17. SOAP-Specific Processing Errors

Error Code	Error Message
UnAuthorized	The signature could not be verified.

8.5.5 MIME-Specific Processing Errors

HETS does not return any MIME specific processing errors.

8.5.6 SOAP and MIME Transaction Error Processing

Transaction processing errors, described in Sections 8.1 through 8.4 of this *Companion Guide*, are returned as a SOAP message or MIME Multipart/form-data containing the related response. Refer to those sections for additional information.

9 Trading Partner Agreements

In order to submit requests to the HETS 270/271 application, a prospective applicant must complete the trading partner registration process via submission of a HETS 270/271 Trading Partner Agreement (TPA). Refer to Section 2.2 of this *Companion Guide* for information regarding registering as a Trading Partner.

HETS Trading Partners will promptly contact the MCARE Help Desk at 1-866-324-7315 if the name of the Authorized Representative noted on the TPA changes. HETS Trading Partners agree to recertify their HETS access annually by re-submitting a new TPA upon CMS request. Failure to complete the recertification process will result in the HETS Trading Partner's loss of access to the HETS 270/271 Application.

The HETS 270/271 application validates that the Clearinghouse or Provider has been established in the Trading Partner Management System (TPMS) prior to processing the 270 transaction. If the Trading Partner (ISA06) cannot be validated, the HETS 270/271 application returns a TA1 Interchange Acknowledgement as outlined in Section 8.1 of this *Companion Guide*.

Trading Partners may not send transactions to be executed with Usage Indicator (ISA15) = “P” until testing has been completed and approval to submit production transactions has been finalized. The HETS 270/271 application returns a TA105 = “020” error for an Invalid Test Indicator Value.

The Trading Partner Rules of Behavior are outlined within the Trading Partner Registration documentation. Please refer to Section 1.3 of this *Companion Guide* for links to these documents.

10 Transaction Specific Information

This section defines specific requirements that CMS requires over and above the standard information in the ASC X12 270/271 version 005010X279A1 TR3 referenced in Section 1.1 of this *Companion Guide*.

10.1 270 Eligibility Request Transaction

This section describes the values required by CMS in the 270 request. Any segments or elements not referenced in the following tables should be submitted on the 270 request as per the ASC X12 270/271 version 005010X279A1 TR3.

10.1.1 Information Source Level Structures

CMS is the Information Source for all Medicare Eligibility Transactions. Table 18 defines specific requirements for the header and information source data.

Table 18. 270 Header and Information Source

Loop ID	Reference	Name	X12 Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	13	HETS does not support cancellations.
2100A	NM1	Information Source Name		
2100A	NM102	Entity Type Qualifier	2	HETS does not support individuals as information sources.
2100A	NM103	Information Source Last or Organization Name		HETS always expects “CMS.”
2100A	NM109	Information Source Primary Identifier		HETS always expects “CMS.”

10.1.2 Information Receiver Level Structures

Trading Partners that submit transactions on behalf of a Provider must ensure that the correct, valid, and active Medicare Provider identification is submitted as the Information Receiver. Only National Provider Identifier (NPI) numbers are accepted. Table 19 defines specific requirements for the Information Receiver data.

Table 19. 270 Information Receiver

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	1P, 80, FA	HETS only sends responses for providers, hospitals, and facilities.
2100B	NM109	Information Receiver Identification Number		The Medicare Enrolled Provider's NPI number.

10.1.3 Subscriber Level Structures

Trading Partners must ensure that only one Medicare beneficiary request is submitted in the Subscriber Level for each 270 request. Table 20 defines specific requirements for the Subscriber Level data.

Table 20. 270 Subscriber

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100C	NM1	Subscriber Name		
2100C	NM103	Subscriber Last Name		Last name is required for Medicare beneficiary identification using the Primary or Alternate Search options. Maximum length allowable is 40 characters.
2100C	NM104	Subscriber First Name		First name is required for Medicare beneficiary identification only when the beneficiary's date of birth is not submitted. Maximum length allowable is 30 characters.
2100C	NM107	Subscriber Name Suffix		When the suffix is part of the Medicare beneficiary's last name on the Medicare card, the suffix is required for last name matching. For convenience, the Subscriber Name Suffix can also be appended to the Subscriber Last Name field to meet matching constraints.
2100C	NM108	Subscriber Identification Code Qualifier	MI	
2100C	NM109	Subscriber Primary Identifier		MBI is required for all Medicare beneficiary Search options. This element must exactly match the ID on the patient's Medicare card.
2100C	DMG	Subscriber Demographic Information		

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100C	DMG02	Subscriber Birth Date		Date of Birth is required for Medicare beneficiary identification only when the beneficiary's first name is not submitted.
2100C	DTP	Subscriber Date		
2100C	DTP01	Date Time Qualifier	291	
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
2110C	EQ01	Service Type Code		HETS will accept all X12 STC codes; however, only those codes specified by this *Companion Guide* will return explicit benefit information. All other X12 codes will return only the basic set of eligibility data as defined in Section 7.2 of this guide.
2110C	EQ02	Composite Medical Procedure Identifier		HETS will accept all valid Procedure codes; however, only those codes specified by this *Companion Guide* will return explicit benefit information. All other valid Procedure codes will return only the basic set of eligibility data.

10.2 271 Eligibility Response Transaction

This section describes the values returned by CMS in the 271 response. The following tables describe the CMS utilization of segments and elements when there is a type of uniqueness or restriction. All other values comply with the ASC X12 270/271 version 005010X279A1 TR3.

Table 21. 271 Header and Information Source

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100A	NM1	Information Source Name		
2100A	NM101	Entity Identifier Code	PR	
2100A	NM108	Identification Code Qualifier	PI	
2100A	NM109	Information Source Primary Identifier		HETS always returns "CMS."

Table 22. 271 Information Receiver

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	1P, 80, FA	
2100B	NM109	Information Receiver Identification Number		The Provider's assigned NPI number as submitted on the 270 request.

Table 23. 271 Subscriber Demographic Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2000C	TRN	Subscriber Trace Number		
2000C	TRN01	Trace Type Code	2	
2100C	NM1	Subscriber Name		
2100C	NM103	Subscriber Last Name		If there are errors in the transaction, HETS will return the value from the 270. If a match is found, HETS will return the value from the CMS Eligibility Database.
2100C	NM104	Subscriber First Name		If there are errors in the transaction, HETS will return the value from the 270. If a match is found, HETS will return the value from the CMS Eligibility Database.
2100C	NM107	Subscriber Name Suffix		
2100C	NM109	Subscriber Primary Identifier		HETS returns the MBI submitted on the 270 request. If a MBI was not submitted on the 270 request, a value of "MISSING" will be returned.
2100C	N3	Subscriber Address		
2100C	N301	Subscriber Address Line		Medicare beneficiary Address Line 1 or "Unknown" if any address lines are missing or invalid on the database.
2100C	N4	Subscriber City State Zip		
2100C	N401	Subscriber City Name		Medicare beneficiary City Name or "Baltimore" if any address lines are missing or invalid on the database.
2100C	N402	Subscriber State Code		Medicare beneficiary State Code or "MD" if any address lines are missing or invalid on the database.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100C	N403	Subscriber Postal Zone or Zip Code		Medicare beneficiary Postal ZIP Code or “21244” if any address lines are missing or invalid on the database.
2100C	DTP	Subscriber Date		
2100C	DTP01	Date Time Qualifier	152, 307 or 442	A value of 152 is returned when the submitted MBI has an end date on file, the 271 response includes benefit information and the request Date(s) of Service overlap the terminated MBI’s effective period.

Table 24. 271 Part D Plan Coverage

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Inquiry		
2110C	EB01	Eligibility or Benefit Information	1 or 6	This information will be returned if STC 30 or 88 is requested, an STC is not present or a Non-Supported STC is requested.
2110C	EB03	Service Type Code	88	This information will be returned if STC 30 or 88 is requested, an STC is not present or a Non-Supported STC is requested.

Table 25. 271 Part A and Part B Plan Level Eligibility

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Refer to Section 7.2 for a list of Medicare Part A and Part B STCs supported by the HETS 270/271 application. HETS returns separate Medicare Part B plan level eligibility when STC 80 is requested on the 270. HETS returns separate Medicare Part B plan level eligibility when STC CO is requested on the 270. If both STC 80 and BO are requested on the 270, plan level eligibility may be combined for these services. Beneficiaries that are enrolled in the Part B Immunosuppressive Drug Benefit (Part B-ID) will return Part B coverage only. Medicare Part A and Part D will return inactive coverage for these beneficiaries. All supported Service Type Codes or HCPCS Codes submitted on the 270 requests will return as inactive benefits on the HETS 271 response when the Medicare beneficiary is enrolled in Part B-ID for the requested Date(s) of Service.
2110C	EB01	Eligibility or Benefit Information	1 or 6	
2110C	EB04	Insurance Type Code	MA or MB	EB04 will be omitted when requested dates are after a Medicare beneficiary's Date of Death. When requested dates are during a period of Incarceration, Deportation or Alien Status, EB04 will be omitted only from the EB segment pertaining to the period of inactivity or ineligibility.
2110C	DTP	Subscriber Eligibility/Benefit Date		If multiple entitlement periods exist, HETS returns them in descending order – future, current, past. For inactive periods, the DTP segment will not be returned.
2110C	DTP01	Date Time Qualifier	291 or 771	771 is used exclusively for Vaccination data when STC 80 or CO is requested on the 270. The corresponding DTP03 value will be the HETS system date.
2110C	MSG	Message Text	MSG	
2110C	MSG01	Free-form Message Text	N/A	If available, HETS returns "<Medicare EntitlementReasonCode> - <MedicareEntitlementReasonCodeText>". See Table 11 for additional information.

Table 26. 271 Part A and Part B Plan Level Deductible

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		
2110C	EB01	Eligibility or Benefit Information	C	
2110C	EB04	Insurance Type Code	MA, MB, or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” or “Medicare Part B” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	23, 26, or 29	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	291 or 292	HETS returns “291” only when EB03 = “30”; otherwise, HETS returns “292.”

Table 27. 271 Part B Plan Level Coinsurance

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Refer to Section 7.2 for a list of Medicare Part B STCs supported by the HETS 270/271 application.
2110C	EB01	Eligibility or Benefit Information	A	
2110C	EB04	Insurance Type Code	MB or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part B” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	27	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	291 or 292	HETS returns “291” when EB03 = “30” only; otherwise, HETS returns “292.”

Table 28. 271 Part B Plan Level Deductible - Supported HCPCS Codes

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Refer to Section 7.2 for a list of HCPCS supported by the HETS 270/271 application. HETS will return preventive service HCPCS codes (see Section 7.10) prior to other HCPCS codes such as audiology.
2110C	EB01	Eligibility or Benefit Information	C	Deductible
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	23 or 29	
2110C	EB13-1	Product or Service ID Qualifier	HC	
2110C	EB13-2	Procedure Code		HCPCS Code
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP03	Eligibility or Benefit Date Time Period		HETS returns the current system transaction processing date.

Table 29. 271 Part B Plan Level Coinsurance - Supported HCPCS Codes

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Refer to Section 7.2 for a list of HCPCS supported by the HETS 270/271 application. HETS will return preventive service HCPCS codes (see Section 7.10) prior to other HCPCS codes such as audiology.
2110C	EB01	Eligibility or Benefit Information	A	Coinsurance
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	27	
2110C	EB13-1	Product or Service ID Qualifier	HC	
2110C	EB13-2	Procedure Code		HCPCS Code

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP03	Eligibility or Benefit Date Time Period		HETS returns the current system transaction processing date.

Table 30. 271 Part A Hospital/SNF Spell Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB03	Service Type Code	30, 48 or AH	HETS returns “30” for Medicare Part A Hospital/SNF DOEBA/DOLBA dates, “48” for Hospital Stay or “AH” for SNF Stay.
2110C	EB04	Insurance Type Code	MA	
2110C	EB06	Time Period Qualifier	27	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292 or 435	HETS returns “292” for Medicare Part A Hospital/SNF DOEBA/DOLBA dates or “435” for Hospital/SNF Stay dates.
2110C	DTP03	Eligibility or Benefit Date Time Period		DOEBA and DOLBA dates of all hospital spells intersecting the current date and/or the calendar (years) of the date/date range of the 270 request.
2120C	NM1	Subscriber Benefit Related Entity Name	NM1	
2120C	NM101	Entity Identifier Code	FA	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM108	Identification Code Qualifier	XX	

Table 31. 271 Part A Hospital and SNF Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Part A Days Allowed Per Spell Loop This loop will repeat for every Part A Spell returned and for each calendar year included in the Plan dates from the 270. Information in this table is for STCs “48”, “49”, “AG”, “A5”, and “A7.” If STC “47” is requested, the HETS 270/271 application will return information for STCs “48” and “49.” Refer to Section 7.2 for more information.
2110C	EB01	Eligibility or Benefit Information	B	
2110C	EB03	Service Type Code	30	
2110C	EB04	Insurance Type Code	MA or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	HSD	Health Care Services Delivery		Hospital Days Base or Base as Remaining Days
2110C	HSD03	Unit or Basis for Measurement Code	DA	
2110C	HSD05	Time Period Qualifier	29, 30 or 31	
2110C	HSD	Healthcare Services Delivery		Hospital Episodes
2110C	HSD05	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	435	
2110C	EB	Subscriber Eligibility or Benefit Information		Part A Days Remaining Per Spell Loop This loop will repeat for every Part A Spell returned and for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	B	
2110C	EB03	Service Type Code	30	
2110C	EB04	Insurance Type Code	MA or QM	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	HSD	Health Care Services Delivery		Hospital Days Remaining
2110C	HSD03	Unit or Basis for Measurement Code	DA	
2110C	HSD05	Time Period Qualifier	29	
2110C	HSD	Health Care Services Delivery		Hospital Episodes
2110C	HSD05	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		DOEBA and DOLBA are related to a single Inpatient Spell and NOT to the individual general benefit.
2110C	DTP01	Date Time Qualifier	435	
2110C	EB	Subscriber Eligibility or Benefit Information		SNF Days Allowed Per Spell Loop This loop will repeat for every Part A Spell returned and for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	B	
2110C	EB03	Service Type Code	AG	
2110C	EB04	Insurance Type Code	MA or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	HSD	Health Care Services Delivery		SNF Days Base or Base as Remaining Days
2110C	HSD03	Unit or Basis for Measurement Code	DA	
2110C	HSD05	Time Period Qualifier	29, 30 or 31	
2110C	HSD	Health Care Services Delivery		SNF Episodes
2110C	HSD05	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	435	N/A

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		SNF Days Remaining Per Spell Loop This loop will repeat for every Part A Spell returned and for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	B	
2110C	EB03	Service Type Code	AG	
2110C	EB04	Insurance Type Code	MA or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	HSD	Health Care Services Delivery		SNF Days Remaining segment
2110C	HSD03	Unit or Basis for Measurement Code	DA	
2110C	HSD05	Time Period Qualifier	29	
2110C	HSD	Health Care Services Delivery		SNF Episodes
2110C	HSD05	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		DOEBA and DOLBA are related to a single Inpatient Spell and NOT to the individual general benefit.
2110C	DTP01	Date Time Qualifier	435	
2110C	EB	Subscriber Eligibility or Benefit Information		Lifetime Reserve Base or Remaining Days Loop This loop will repeat for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	K	
2110C	EB03	Service Type Code	30	
2110C	EB04	Insurance Type Code	MA	
2110C	EB06	Time Period Qualifier	32 or 33	
2110C	EB09	Quantity Qualifier	DY	
2110C	EB	Subscriber Eligibility or Benefit Information		Lifetime Reserve Copayment per Day Amount Loop This loop will repeat for each calendar year included in the Plan dates from the 270.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information	K	
2110C	EB03	Service Type Code	30	
2110C	EB04	Insurance Type Code	MA or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	435	
2110C	EB	Subscriber Eligibility or Benefit Information	EB	Psychiatric Limitation Days Loop This loop will repeat for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	K	
2110C	EB03	Service Type Code	A7	
2110C	EB04	Insurance Type Code	MA	
2110C	EB06	Time Period Qualifier	32 or 33	
2110C	EB09	Quantity Qualifier	DY	

Table 32. 271 Home Health Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information	EB	Home Health Loop Information in this table will be returned on the 271 response when STC “42” is submitted on a 270 request. Home Health Data will be returned only for episodes with end dates.
2110C	EB01	Eligibility or Benefit Information	X	N/A
2110C	EB06	Time Period Qualifier	26	N/A
2110C	DTP	Subscriber Eligibility/Benefit Date	DTP	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP01	Date Time Qualifier	472, 193 or 194	HETS returns “472” for Home Health Start and End Dates; HETS returns “193” for DOEBA and “194” for DOLBA.
2110C	MSG	Message Text	MSG	
2110C	MSG01	Free-form Message Text	N/A	If available, HETS returns “<PatientStatusCode> - <PatientStatusCodeText>”
2110C	MSG	Message Text	MSG	
2110C	MSG01	Free-form Message Text	N/A	If available, HETS returns “NOA - <NOAIndicatort>”
2120C	NM1	Subscriber Benefit Related Entity Name	NM1	
2120C	NM101	Entity Identifier Code	PR	N/A
2120C	NM102	Entity Type Qualifier	2	N/A
2120C	NM103	Benefit Related Entity Last or Organization Name	N/A	HETS returns “National Government Services, Inc.”, “National Heritage Insurance Company”, “Palmetto GBA”, or “United Government Services, CA.”
2120C	NM108	Identification Code Qualifier	PI	N/A
2120C	NM109	Benefit Related Entity Identifier	N/A	HETS returns 00180, 00380, 00450, 00454, 00456,06001, 06004,06014,11004, 14004 or 14014
2120C	NM1	Subscriber Benefit Related Entity Name	NM1	
2120C	NM101	Entity Identifier Code	1P	N/A
2120C	NM103	Name Last or Organization Name	N/A	If a Contractor name is unavailable, HETS will return the Contract Number (NM109) alone without the Contractor name in NM103.
2120C	NM108	Identification Code Qualifier	XX	N/A
2110C	EB	Subscriber Eligibility or Benefit Information	EB	Home Health Certification Loop
2110C	EB01	Eligibility or Benefit Information	X	N/A
2110C	EB13	Composite Medical Procedure Identifier	HC| G0180	HETS returns “HC|G0180” to indicate Home Health Certification.
2110C	DTP	Subscriber Eligibility/Benefit Date	DTP	
2110C	DTP01	Date Time Qualifier	193	HH Certification date

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information	EB	Home Health Recertification Loop
2110C	EB01	Eligibility or Benefit Information	X	N/A
2110C	EB13	Composite Medical Procedure Identifier	HC| G0179	HETS returns “HC|G0179” to indicate Home Health Recertification.
2110C	DTP	Subscriber Eligibility/Benefit Date	DTP	
2110C	DTP01	Date Time Qualifier	193	HH Recertification date

Table 33. 271 HCPCS Benefit Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		HETS will respond to supported HCPCS codes submitted in the 270 request. See Section 7.2 for a list of supported HCPCS codes. HETS will return preventive service HCPCS codes (see Section 7.10) prior to other HCPCS codes such as audiology.
2110C	EB01	Eligibility or Benefit Information	D or 6	HETS may return “6” to indicate ineligibility for particular IPPE HCPCS codes.
2110C	EB04	Insurance Type Code	MB	
2110C	EB13-1	Product or Service ID Qualifier	HC	
2110C	EB13-3	Procedure Modifier	26 or TC	If applicable, HETS returns “26” or “TC.” HETS will omit EB13-3 if the next eligible dates of the HCPCS professional and technical components are the same.
2110C	DTP	DTP		
2110C	DTP01	Date Time Qualifier	348 or 472	HETS returns “348” when returning next eligible dates. HETS returns “472” when prior service history is returned for PPV HCPCS.
2120C	NM1	Subscriber Benefit Related Entity Name	NM1	HETS only returns elements NM101 – NM108 for PPV Preventive HCPCS 90670, 90671, 90677 and/or 90732 codes, which return prior service history. See Section 7.10.2 for additional details.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2120C	NM101	Entity Identifier Code	1P	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM108	Identification Code Qualifier	XX	

Table 34. 271 Smoking/Tobacco Cessation Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Smoking/Tobacco Cessation Sessions Remaining Loop Information in this table will be returned on the 271 response when STC “67” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	F	
2110C	EB03	Service Type Code	67	
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	22	
2110C	EB09	Quantity Qualifier	VS	N/A
2100C	EB10	Quantity	N/A	Smoking/Tobacco Cessation Base Sessions
2110C	HSD	Health Care Services Delivery		
2110C	HSD01	Quantity Qualifier	VS	
2100C	HSD02	Quantity	N/A	Smoking/Tobacco Cessation Remaining Sessions
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP03	Date Time Period	N/A	If applicable, HETS returns the Smoking/Tobacco Cessation Initial Session Date (within the last 12 months based on HETS system date)

Table 35. 271 Therapy Services Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Occupational Therapy Service Loop Refer to Section 7.12 for a list of Medicare Therapy Services supported by the HETS 270/271 application. Information in this section will be returned on the 271 response when STC “AD” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB04	Insurance Type Code	MB	
2110C	EB07	Benefit Amount		HETS returns the Occupational Therapy Used Amount.
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Used Amount.”
2110C	EB	Subscriber Eligibility or Benefit Information		Physical/Speech Therapy Used Loop Information in this section will be returned on the 271 response when STC “AE” and/or “AF” are submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB03	Service Type Code	AE	HETS always returns “AE” regardless of whether “AE”, “AF”, or “AE/AF” is requested.
2110C	EB04	Insurance Type Code	MB	
2110C	EB07	Benefit Amount		HETS returns the combined Physical/Speech Therapy Used Amount.
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Used Amount.”

Table 36. 271 Pulmonary Rehabilitation Services

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Pulmonary Rehabilitation Loop Refer to Section 7.13 for a list of Medicare Pulmonary Rehabilitation Services supported by the HETS 270/271 application. Information in this table will be returned on the 271 response when STC “BF” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	F	
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	29	
2110C	EB09	Quantity Qualifier	CA	
2110C	EB10	Quantity		HETS returns the number of Pulmonary Rehabilitation sessions remaining.
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Professional” or “Technical.”

Table 37. 271 Cardiac Rehabilitation Services

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Cardiac Rehabilitation Loop Refer to Section 7.14 for a list of Medicare Cardiac Rehabilitation Services supported by the HETS 270/271 application. Information in this table will be returned on the 271 response when STC “BG” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	F	
2110C	EB04	Insurance Type Code	MB	
2110C	EB09	Quantity Qualifier	99	
2110C	EB10	Quantity		HETS returns the number of Cardiac Rehabilitation sessions used.
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Professional” or “Technical.”

Table 38. 271 Intensive Cardiac Rehabilitation Services

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Intensive Cardiac Rehabilitation Loop Refer to Section 7.14 for a list of Medicare Intensive Cardiac Rehabilitation Services supported by the HETS 270/271 application. Information in this table will be returned on the 271 response when STC “BG” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	F	
2110C	EB04	Insurance Type Code	MB	
2110C	EB09	Quantity Qualifier	99	
2110C	EB10	Quantity		HETS returns the number of Intensive Cardiac Rehabilitation sessions used.
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Intensive Cardiac Rehabilitation- Professional” or “Intensive Cardiac Rehabilitation-Technical.”

Table 39. 271 ESRD Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		ESRD Loops Information in this table will be returned on the 271 response when STC “CQ” or “RN” is submitted on a 270 request. Refer to Section 7.15
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB03	Service Type Code	RN	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	HETS returns any ESRD Coverage Period that overlaps the requested Date(s) of Service. If the ESRD Coverage Period is ongoing, then only the coverage start date will be returned.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP02	Date Time Format Qualifier		HETS returns 'D8' if the ESRD period only has a start date. HETS returns 'RD8' if the ESRD period has a start and end date.
2110C	DTP	Subscriber Eligibility/Benefit Date	DTP	Beginning of segment
2110C	DTP01	Date Time Qualifier	472	If the associated ESRD Coverage Period includes a Clinical Dialysis Period, HETS returns ESRD Clinical Dialysis information with a '472' qualifier in DTP01. If the ESRD Clinical Dialysis period is ongoing, then only a coverage start date will be returned.
2110C	DTP02	Date Time Format Qualifier		HETS returns 'D8' if the ESRD Clinical Dialysis period only has a start date. HETS returns 'RD8' if the ESRD Clinical Dialysis period has a start and end date.
2110C	DTP	Subscriber Eligibility/Benefit Date	DTP	Beginning of segment
2110C	DTP01	Date Time Qualifier	096	If the associated ESRD Coverage Period includes an ESRD Transplant Effective Date, HETS returns that ESRD Transplant Effective date.
2110C	DTP02	Date Time Format Qualifier	D8	If applicable, HETS returns 'D8' and then the ESRD Transplant Effective Date in DTP03.

Table 40. 271 Hospice Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Hospice Occurrence Loop Information in this table will be returned on the 271 response when STC "45" is submitted on a 270 request. Refer to Section 7.16.
2110C	EB01	Eligibility or Benefit Information	X	
2110C	EB04	Insurance Type Code	MA	
2110C	EB06	Time Period Qualifier	26	
2110C	HSD	Health Care Services Delivery	HSD	Hospice Days Used (for up to fifty billed Hospice Benefit Periods)
2110C	HSD01	Quantity Qualifier	DY	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	HSD02	Quantity		Hospice Days Used in the billed Hospice Benefit Period (for up to fifty Hospice episodes)
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292, 318, 349, 435	HETS returns '292' for Hospice start and/or end dates (including Election [NOE] periods). HETS returns '318' for Hospice Election (NOE) Receipt Date. HETS returns '349' for Hospice Election Revocation Date. HETS returns '435' for Hospice DOEBA-DOLBA for up to fifty billed Hospice Benefit Periods.
2110C	DTP02	Date Time Format Qualifier	D8, RD8	If applicable, HETS returns 'D8' for Notice of Election (NOE) periods and 'RD8' for Hospice Benefit Periods.
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text	N/A	HETS returns "Revocation code – [Revocation code value]." Revocation code values returned are: 0, 1, 2, or 3.
2120C	NM1	Subscriber Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	1P	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM108	Identification Code Qualifier	XX	

Table 41. 271 Blood Deductible Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Blood Deductible Loop Information in this table will be returned on the 271 response when STC "10" is submitted on a 270 request. Refer to Section 7.17.
2110C	EB01	Eligibility or Benefit Information	E	
2110C	EB03	Service Type Code	10	
2110C	EB06	Time Period Qualifier	23	
2110C	EB09	Quantity Qualifier	DB	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB10	Benefit Quantity	N/A	HETS returns the base number of Blood Deductible units.
2110C	HSD	Health Care Services Delivery		
2110C	HSD01	Quantity Qualifier	FL	
2110C	HSD02	Quantity	N/A	HETS returns the number of Blood Deductible Units Remaining.
2110C	HSD05	Time Period Qualifier	29	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	

Table 42. 271 Part D Enrollment Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Part D Enrollment Loop Refer to Section 7.18.
2110C	EB01	Eligibility or Benefit Information	R	
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	18	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		Part D Contract Number
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	N6	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		Part D Plan Number (if available)
2110C	REF03	Description		Part D Plan Name (if available)
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2120C	NM1	Subscriber Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	PR	
2120C	NM102	Entity Type Qualifier	2	
2120C	N301	Benefit Related Entity Address Line		Medicare Insurer Address Line 1 if valid, otherwise not sent.
2120C	N302	Benefit Related Entity Address Line		Medicare Insurer Address Line 2 if valid, otherwise not sent.
2120C	N401	Benefit Related Entity City Name		Medicare Insurer City Name
2120C	N402	Benefit Related Entity State Code		Medicare Insurer State Code
2120C	N403	Benefit Related Entity Postal Zone or Zip Code		Medicare Insurer Postal ZIP Code
2120C	PER	Subscriber Benefit Related Entity Contact Information		HETS returns the telephone number or website address in the PER03 and PER04 elements when the Part D plan has only a telephone number or only a website address. If neither exists, then HETS does not return the PER segment.

Table 43. 271 Medicare Advantage (MA) Enrollment Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		MA Loop Refer to Section 7.19.
2110C	EB01	Eligibility or Benefit Information	U	HETS returns a 271 2110C EB01 of ‘U’ for MA plans. CMS strongly recommends that Medicare Providers/Suppliers contact the MA plan directly to confirm the beneficiary’s MA plan eligibility information.
2110C	EB03	Service Type Code	30 or 30^CQ	HETS 270/271 returns a 271 2110C EB03 value of “30^CQ” when the beneficiary is enrolled in a MA plan and STC 'CQ' was included on the 270 request.
2110C	EB04	Insurance Type Code	HM, HN, IN, PR, or PS	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	18	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		MA Contract Number
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	N6	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		MA Plan Number (if available)
2110C	REF03	Description		MA Plan Name (if available)
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	290	
2110C	MSG	Message Text		
2110C	MSG01	Free Form Message Text		HETS returns “MA Bill Option Code – [code value].” Code values returned are A, B, C, 1 or 2.
2120C	NM1	Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	PR or PRP	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM103	Benefit Related Entity Last or Organization Name		HETS returns the MA Insurer Name.
2120C	N301	Benefit Related Entity Address Line		Medicare Insurer Address Line 1 if valid, otherwise not sent.
2120C	N302	Benefit Related Entity Address Line		Medicare Insurer Address Line 2 if valid, otherwise not sent.
2120C	N401	Benefit Related Entity City Name		Medicare Insurer City Name
2120C	N402	Benefit Related Entity State Code		Medicare Insurer State Code

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2120C	N403	Benefit Related Entity Postal Zone or Zip Code		Medicare Insurer Postal ZIP Code
2120C	PER	Benefit Related Entity Contact Information		HETS returns the telephone number or website address in the PER03 and PER04 elements when the MA plan has only a telephone number or only a website address. If neither exists, then HETS does not return the PER segment.

Table 44. 271 Medicare Secondary Payer (MSP) Enrollment Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		MSP Loop Refer to Section 7.20
2110C	EB01	Eligibility or Benefit Information	R	N/A
2110C	EB04	Insurance Type Code		HETS returns codes: 12, 13, 14, 15, 16, 41, 42, 43, 47, AP, or WC
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	IG, 6P	HETS returns REF01 of IG for MSP Insurance Type Code. The HETS 271 MSP response with REF01 equal to '6P' will include either the MSP Insurance Group Number or the MSP Date of Loss. If the returned value is a series of zeroes, this indicates that while there is an MSP enrollment record in the Common Working File (CWF), the CWF record does not include the actual MSP Insurance Group Number. If the returned value begins with the acronym 'DOL' (Date of Loss) then the subsequent value is the Date of Loss.
2110C	REF02	Subscriber Eligibility or Benefit Identifier		
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	290, 636	HETS returns DTP01 of 290 for MSP Enrollment Period(s). HETS returns DTP01 of 636 for MSP Last Maintenance Date.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	MSG	Message Text		
2110C	MSG01	Free Form Message Text		HETS returns the ORM indicator. Refer to Section 7.20 for more information.
2110C	MSG01	Free Form Message Text		HETS returns any applicable diagnosis codes related to the MSP enrollment period detailed in the prior EB/REF/DTP loops. HETS returns diagnosis codes in this field, with multiple values (if applicable) separated by commas.
2110C	MSG01	Free Form Message Text		HETS returns the MSP Source Code and its text value description.
2110C	MSG01	Free Form Message Text		HETS returns the MSP Patient Relationship Code and its text value description.
2120C	NM1	Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	PRP	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM103	Benefit Related Entity Last or Organization Name		HETS returns the Primary Insurer Name.
2120C	N3	Benefit Related Entity Address	N3	Beginning of segment
2120C	N301	Benefit Related Entity Address Line		Primary Insurer Address Line 1 if valid, otherwise not sent.
2120C	N302	Benefit Related Entity Address Line		Primary Insurer Address Line 2 if valid, otherwise not sent.
2120C	N4	Benefit Related Entity City State Zip	N4	
2120C	N401	Benefit Related Entity City Name		Primary Insurer City if valid, otherwise not sent.
2120C	N402	Benefit Related Entity State Code		Primary Insurer State Code
2120C	N403	Benefit Related Entity Postal Zone or Zip Code		Primary Insurer ZIP Code

Table 45. 271 Qualified Medicare Beneficiary (QMB) Periods

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		QMB Loop Refer to Section 7.21.
2110C	EB01	Eligibility or Benefit Information	R	N/A
2110C	EB04	Insurance Type Code	QM	Qualified Medicare Beneficiary
2100C	EB05	Plan Coverage Description		HETS returns the Medicaid enrollment State Code + “QMB Plan.”
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	290	
2110C	DTP02	Date Time Format Qualifier		HETS returns ‘D8’ if the QMB period is still active and only has a start date. HETS returns ‘RD8’ if the QMB period has an end date.

Table 46. 271 Medicare Diabetes Prevention Program (MDPP) Services

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		MDPP entitlement Loop. Information in this section will be returned on the 271 response when STC “CQ” is submitted on a 270 request. Refer to Section 7.22.
2110C	EB01	Eligibility or Benefit Information	1 or 6	
2110C	EB03	Service Type Code	CQ	
2110C	EB04	Insurance Type Code	MB	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	194 or 292	DTP01 qualifier 194 is only used for loops that include a Medicare beneficiary’s end date for MDPP Period 2; this end date is factored into the MDPP ineligible coverage response in the prior EB segment.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP02	Date Time Format Qualifier		HETS typically returns the same DTP02 qualifier and dates submitted on the 270 request. If the requested dates intersect date(s) without active Part B entitlement, then multiple DTP segments will be returned to illustrate periods of eligibility or ineligibility.
2110C	EB	Subscriber Eligibility or Benefit Information		MDPP Deductible (reflecting zero due)
2110C	EB01	Eligibility or Benefit Information	C	
2110C	EB03	Service Type Code	CQ	
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	23	
2110C	EB07	Monetary Amount	0	MDPP services require zero deductible
2110C	DTP	Subscriber Eligibility/Benefit Date		Beginning of segment.
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP02	Date Time Format Qualifier		If the requested dates intersect date(s) without active Part B entitlement, DTP segments will be returned to illustrate only eligible MDPP periods.
2110C	EB	Subscriber Eligibility or Benefit Information		MDPP Coinsurance (reflecting zero due)
2110C	EB01	Eligibility or Benefit Information	A	
2110C	EB03	Service Type Code	CQ	
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	27	
2110C	EB08	Monetary Amount	0	MDPP services require zero coinsurance
2110C	DTP	Subscriber Eligibility/Benefit Date		Beginning of segment.
2110C	DTP01	Date Time Qualifier	292	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP02	Date Time Format Qualifier		
2110C	DTP03	Date Time Period		If the requested dates intersect date(s) without active Part B entitlement, DTP segments will be returned to illustrate only eligible MDPP periods.
2110C	EB	Subscriber Eligibility or Benefit Information		MDPP Usage Detail
2110C	EB01	Eligibility or Benefit Information	1 or D	
2110C	EB04	Insurance Type Code	MB	
2110C	EB13-1	Product or Service ID Qualifier		HC
2110C	EB13-2	Procedure Code		MDPP HCPCS Code
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	472	
2110C	DTP02	Date Time Format Qualifier	D8	
2110C	DTP03	Date Time Period		Date the MDPP service was rendered
2120C	NM1	Subscriber Benefit Related Entity Name		MDPP Rendering Provider Information
2120C	NM101	Entity ID Code	1P	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM108	Identification Code Qualifier	XX	
2120C	NM109	Identification Code		NPI of the MDPP Supplier that rendered service

Table 47. 271 Acupuncture Services

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Acupuncture Services Loop. Information in this section will be returned on the 271 response when STC “64” is submitted on a 270 request. Refer to Section 7.23.
2110C	EB01	Eligibility or Benefit Information	F	
2110C	EB03	Service Type Code	64	
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	29	
2110C	EB09	Quantity Qualifier	CA	
2110C	EB10	Quantity		HETS returns the number of Acupuncture sessions remaining.
2110C	DTP	Subscriber Eligibility/ Benefit Date		
2110C	DTP01	Date Time Qualifier	472	
2110C	DTP02	Date Time Format Qualifier	D8	
2110C	DTP03	Date Time Period		If the number of sessions remaining returned in the prior EB10 element is twenty (’20’), then this DTP03 value is the next eligible date. If the number of sessions remaining returned in the prior EB10 element is one through nineteen (‘1’ – ‘19’), then this DTP03 value is the first Acupuncture session in the current annual period. If the Medicare beneficiary does not have active Medicare Part B entitlement and/or has a Date of Death on file, HETS will return zero (‘0’) sessions remaining and no 271 2110C DTP loop would be returned.
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Professional” or “Technical” to describe the Next Eligible Date in the prior DTP03 element.

Table 48. 271 Vaccination

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Vaccination Loop. COVID-19 vaccination information will be returned on the 271 response when STC “80” is submitted on a 270 request. Flu vaccination information will be returned on the 271 response when STC ‘CO’ is submitted on a 270 request. Refer to Section 7.24.
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB13-1	Product or Service ID Qualifier	HC	
2110C	EB13-2	Procedure Code		COVID-19 or Flu Vaccine or Vaccine Administration Code
2110C	DTP	Subscriber Eligibility/ Benefit Date		
2110C	DTP01	Date Time Qualifier	472	
2110C	DTP02	Date Time Format Qualifier	D8	
2110C	DTP03	Date Time Period		Vaccine or Vaccine Administration Date
2120C	NM1	Subscriber Benefit Related Entity Name		Vaccination Rendering Provider Information
2120C	NM101	Entity ID Code	1P	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM108	Identification Code Qualifier	XX	
2120C	NM109	Identification Code		NPI of the Provider that rendered service

Table 49. 271 Cognitive Assessment and Care Plan

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Cognitive Assessment and Care Plan Loop. Cognitive information will be returned on the 271 response when STC “BD” is submitted on a 270 request for Medicare beneficiaries with active Medicare Part B entitlement. This information is not returned if the Medicare beneficiary has a recorded Date of Death prior to or equal to the Date(s) of Service. Refer to Section 7.25.
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB13-1	Product or Service ID Qualifier	HC	
2110C	EB13-2	Procedure Code	99483	
2110C	DTP	Subscriber Eligibility/ Benefit Date		The HETS 271 response will include all prior Cognitive Assessment and Care Plan Services rendered within the requested Date(s) of Service. If there were no services provided during the requested Date(s) of Service but there is prior usage, then the HETS 271 response will include the most recent service occurrence.
2110C	DTP01	Date Time Qualifier	472	
2110C	DTP02	Date Time Format Qualifier	D8	
2110C	DTP03	Date Time Period		Vaccine or Vaccine Administration Date
2120C	NM1	Subscriber Benefit Related Entity Name		Rendering Provider Information
2120C	NM101	Entity ID Code	1P	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM108	Identification Code Qualifier	XX	
2120C	NM109	Identification Code		NPI of the Provider that rendered service

Table 50: 271 Prior Authorization Indicator

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Prior Authorization Loop. Refer to Section 7.2
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB11	Yes / No Condition or Response Code	Y, N	HETS 271 response can include an indicator with a yes or no value indicating if a prior authorization is required.
2110C	EB13-1	Product or Service ID Qualifier	HC	
2110C	EB13-2	Procedure Code		

Appendix A – Sample 270 Eligibility Request Transaction

This example includes the minimum required data elements for a HETS 270 request. Additional data may be submitted but may also negatively affect the HETS response.

Sample 270 Eligibility Request

□0000000581□
ISA*00* *00* *ZZ*SUBMITTERID *ZZ*CMS *230915*0734*^*00501*000005014*1*P*|~
GS*HS*SUBMITTERID*CMS*20230915*073411*5014*X*005010X279A1~
ST*270*000000001*005010X279A1~
BHT*0022*13*TRANSA*20230915*073411~
HL*1**20*1~
NM1*PR*2*CMS*****PI*CMS~
HL*2*1*21*1~
NM1*1P*2*IRNAME*****XX*1234567893~
HL*3*2*22*0~
TRN*1*TRACKNUM*ABCDEFGHIJ~
NM1*IL*1*LNAME*FNAME****MI*1EG4TE5MK73~
DMG*D8*19400401~
DTP*291*RD8*20220101-20230917~
EQ*10^14^30^42^45^48^64^67^80^A7^AD^AE^AG^BD^BF^BG^CO^RN~
EQ**HC|80061~
EQ**HC|G0327~
EQ**HC|G0402~
EQ**HC|15820~
SE*17*000000001~
GE*1*5014~
IEA*1*000005014~
□

Appendix B – Sample 271 Eligibility Response

Not all of the information presented in this example will be present on every HETS 271 response. This example is for illustrative purposes only and shows the various eligibility information that a 271 response may contain, including Part A, Part B, SNF, Hospital, Preventive, Smoking Cessation, Blood Deductible, Hospice, MSP (including MSP enrollment diagnosis codes), Home Health, Medicare Advantage, Part D, Inactive Periods, Preventive HCPCS, Rehabilitation, Acupuncture, Immunization, Prior Authorization, and Occupational, Physical & Speech Therapies. This example does not include QMB Periods, MDPP, or Part B-ID benefits.

Sample 271 Eligibility Response

□0000006270□
ISA*00* *00* *ZZ*CMS *ZZ*SUBMITTERID *230915*0734*^*00501*111111111*0*P*|~
GS*HB*CMS*SUBMITTERID*20230915*07340000*1*X*005010X279A1~
ST*271*0001*005010X279A1~
BHT*0022*11*TRANSA*20230915*07342355~
HL*1**20*1~
NM1*PR*2*CMS*****PI*CMS~
HL*2*1*21*1~
NM1*1P*2*IRNAME*****XX*1234567893~
HL*3*2*22*0~
TRN*2*TRACKNUM*ABCDEFGHIJ~
NM1*IL*1*LNAME*FNAME*M***MI*1EG4TE5MK73~
N3*ADDRESSLINE1*ADDRESSLINE2~
N4*CITY*ST*ZIPCODE~
DMG*D8*19400401*F~
DTP*307*RD8*20220101-20230917~
EB*6**30~
DTP*307*RD8*20220101-20220108~
EB*I**41^54~
EB*1**88~
EB*D*********Y**HC|15820~
EB*1**30^10^42^45^48^49^69^76^83^A5^A7^AG^BT^BU^BV^RN*MA~
DTP*291*D8*20050401~
MSG*0 – Beneficiary insured due to age OASI~
EB*D**30*MA~
DTP*292*RD8*20220116-20220120~
EB*D**48*MA~
DTP*435*D8*20220116-20220120~
LS*2120~
NM1*FA*2******XX*1234567893~
LE*2120~
EB*C**30*MA**26*1600~
DTP*291*RD8*20230101-20231231~
EB*C**30*MA**26*1556~
DTP*291*RD8*20220101-20221231~
EB*C**30*MA**29*1600~
DTP*291*RD8*20230101-20231231~
EB*C**30*MA**29*1556~
DTP*291*RD8*20220101-20221231~

EB*C**30*MA**29*0~
DTP*291*RD8*20220116-20220120~
EB*C**42^45*MA**26*0~
DTP*292*RD8*20230101-20231231~
DTP*292*RD8*20220101-20221231~
EB*B**30*MA**26*0~
HSD***DA**30*0~
HSD***DA**31*60~
HSD*****26*1~
DTP*435*RD8*20230101-20231231~
EB*B**30*MA**7*400~
HSD***DA**30*60~
HSD***DA**31*90~
HSD*****26*1~
DTP*435*RD8*20230101-20231231~
EB*B**30*MA**26*0~
HSD***DA**30*0~
HSD***DA**31*60~
HSD*****26*1~
DTP*435*RD8*20220101-20221231~
EB*B**30*MA**7*389~
HSD***DA**30*60~
HSD***DA**31*90~
HSD*****26*1~
DTP*435*RD8*20220101-20221231~
EB*B**30*MA**26*0~
HSD***DA**29*60~
HSD*****26*1~
DTP*435*RD8*20230101-20231231~
EB*B**30*MA**7*400~
HSD***DA**29*30~
HSD*****26*1~
DTP*435*RD8*20230101-20231231~
EB*B**30*MA**26*0~
HSD***DA**29*60~
HSD*****26*1~
DTP*435*RD8*20220101-20221231~
EB*B**30*MA**7*389~
HSD***DA**29*30~
HSD*****26*1~
DTP*435*RD8*20220101-20221231~
EB*B**30*MA**26*0~
HSD***DA**29*56~
HSD*****26*1~
DTP*435*RD8*20220116-20220120~
EB*B**30*MA**7*389~
HSD***DA**29*30~
HSD*****26*1~
DTP*435*RD8*20220116-20220120~
EB*B**AG*MA**26*0~
HSD***DA**30*0~
HSD***DA**31*20~
HSD*****26*1~

DTP*435*RD8*20230101-20231231~
EB*B**AG*MA**7*200~
HSD***DA**30*20~
HSD***DA**31*100~
HSD*****26*1~
DTP*435*RD8*20230101-20231231~
EB*B**AG*MA**26*0~
HSD***DA**30*0~
HSD***DA**31*20~
HSD*****26*1~
DTP*435*RD8*20220101-20221231~
EB*B**AG*MA**7*194.5~
HSD***DA**30*20~
HSD***DA**31*100~
HSD*****26*1~
DTP*435*RD8*20220101-20221231~
EB*B**AG*MA**26*0~
HSD***DA**29*20~
HSD*****26*1~
DTP*435*RD8*20230101-20231231~
EB*B**AG*MA**7*200~
HSD***DA**29*80~
HSD*****26*1~
DTP*435*RD8*20230101-20231231~
EB*B**AG*MA**26*0~
HSD***DA**29*20~
HSD*****26*1~
DTP*435*RD8*20220101-20221231~
EB*B**AG*MA**7*194.5~
HSD***DA**29*80~
HSD*****26*1~
DTP*435*RD8*20220101-20221231~
EB*B**AG*MA**26*0~
HSD***DA**29*16~
HSD*****26*1~
DTP*435*RD8*20220116-20220120~
EB*B**AG*MA**7*194.5~
HSD***DA**29*80~
HSD*****26*1~
DTP*435*RD8*20220116-20220120~
EB*K**30*MA**32***DY*60~
EB*K**30*MA**33***DY*58~
EB*K**30*MA**7*800~
DTP*435*RD8*20230101-20231231~
EB*K**30*MA**7*778~
DTP*435*RD8*20220101-20221231~
EB*K**A7*MA**32***DY*190~
EB*K**A7*MA**33***DY*180~
EB*1**30^2^3^5^10^14^23^24^25^26^27^28^33^36^37^38^39^40^42^50^51^52^53^64^67^69^73^76^83^86
^98^A4^A6^A8^AD^AE^AF^AI^AJ^AK^AL^BD^BF^BG^BT^BU^BV^DM^RN^UC*MB~
DTP*291*D8*20050401~
MSG*0 – Beneficiary insured due to age OASI~
EB*1**80^CO*MB~

DTP*771*D8*20230315~
EB*C**30*MB**23*226~
DTP*291*RD8*20230101-20231231~
EB*C**30*MB**23*233~
DTP*291*RD8*20220101-20221231~
EB*C**30*MB**29*0~
DTP*291*RD8*20230101-20231231~
EB*C**30*MB**29*0~
DTP*291*RD8*20220101-20221231~
EB*A**30*MB**27**.2~
DTP*291*RD8*20230101-20231231~
EB*A**30*MB**27**.2~
DTP*291*RD8*20220101-20221231~
EB*C**42^67^80^AJ^CO*MB**23*0~
DTP*292*RD8*20230101-20231231~
EB*C**42^67^AJ*MB**23*0~
DTP*292*RD8*20220101-20221231~
EB*A**42^67^80^AJ^CO*MB**27**0~
DTP*292*RD8*20230101-20231231~
EB*A**42^67^AJ*MB**27**0~
DTP*292*RD8*20220101-20221231~
EB*C***MB**23*0******HC|80061~
DTP*292*D8*20230315~
EB*C***MB**23*0******HC|G0327~
DTP*292*D8*20230315~
EB*A***MB**27**0*****HC|80061~
DTP*292*D8*20230315~
EB*A***MB**27**0*****HC|G0327~
DTP*292*D8*20230315~
EB*D***MB*********HC|80061~
DTP*348*D8*20130105~
EB*D***MB*********HC|G0327~
DTP*348*D8*20190107~
EB*6***MB*********HC|G0402~
EB*F**67*MB**22***VS*8~
HSD*VS*6***29~
DTP*292*D8*20220501~
EB*D**AD*MB***200~
DTP*292*RD8*20230101-20231231~
MSG*USED AMOUNT~
EB*D**AD*MB***1345~
DTP*292*RD8*20220101-20221231~
MSG*USED AMOUNT~
EB*D**AE*MB***0~
DTP*292*RD8*20230101-20231231~
MSG*USED AMOUNT~
EB*D**AE*MB***0~
DTP*292*RD8*20220101-20221231~
MSG*USED AMOUNT~
EB*F**BF*MB**29***CA*72~
MSG*Technical~
EB*F**BF*MB**29***CA*72~
MSG*Professional~

EB*F**BG*MB*****99*0~
MSG*Technical~
EB*F**BG*MB*****99*0~
MSG*Professional~
EB*F**BG*MB*****99*15~
MSG*Intensive Cardiac Rehabilitation – Technical~
EB*F**BG*MB*****99*15~
MSG*Intensive Cardiac Rehabilitation – Professional~
EB*F**64*MB**29***CA*19~
DTP*472*D8*20230107~
MSG*Technical~
EB*F**64*MB**29***CA*20~
DTP*472*D8*20221110~
MSG*Professional~
EB*X**42***26~
DTP*472*RD8*20211222-20220116~
MSG*09 – Admitted as an Inpatient to this Hospital~
MSG*NOA – 1~
LS*2120~
NM1*PR*2*ORGNAME*****PI*CONTR~
NM1*1P*2******XX*1234567890~
LE*2120~
EB*X***********HC|G0180~
DTP*193*D8*20220521~
EB*X***********HC|G0179~
DTP*193*D8*20220917~
DTP*193*D8*20220719~
EB*X**45*MA**26~
DTP*292*D8*20180328~
DTP*318*D8*20180401~
DTP*349*D8*20180430~
MSG*Revocation Code – 1~
LS*2120~
NM1*1P*2******XX*1234567890~
LE*2120~
EB*X**45*MA**26~
HSD*DY*7~
DTP*292*RD8*20180405-20180411~
DTP*435*RD8*20180405-20180411~
LS*2120~
NM1*1P*2******XX*1234567890~
LE*2120~
EB*D**RN~
DTP*292*D8*20190201~
EB*E**10***23***DB*3~
HSD*FL*1***29~
DTP*292*RD8*20230101-20231231~
EB*E**10***23***DB*3~
HSD*FL*2***29~
DTP*292*RD8*20220101-20221231~
EB*R**88*OT~
REF*18*S1234~
REF*N6*001*PLANNAME~

DTP*292*D8*20130101~
LS*2120~
NM1*PRP*2*ORGNAME~
N3*ADDRESSLINE1*ADDRESSLINE2~
N4*CITY*ST*ZIPCODE~
PER*IC**TE*AAABBBCCCC*UR*www.website.com~
LE*2120~
EB*U**30*IN~
REF*18*H1234~
REF*N6*001*PLANNAME~
DTP*290*D8*20090101~
MSG*MA Bill Option Code- C~
LS*2120~
NM1*PRP*2*ORGNAME~
N3*ADDRESSLINE1*ADDRESSLINE2~
N4*CITY*ST*ZIPCODE~
PER*IC**TE*AAABBBCCCC*UR*www.website.com~
LE*2120~
EB*R**30*13~
REF*IG*MSPPOLICYNUMBER~
REF*6P*MSPGROUPNUMBERORDATEOFLOSS~
DTP*290*RD8*20110601-20200131~
DTP*636*D8*20200131~
MSG*ORM – Y~
MSG*S8002XA,S40012A,S93609A,G5622~
MSG*Source Code- MSPSOURCECODE– MSP SOURCECODE VALUE DESCRIPTOR~
MSG*Patient Relationship- MSPPATIENTRELATIONSHIPCODE– MSP PATIENT RELATIONSHIP CODE VALUE DESCRIPTOR~
LS*2120~
NM1*PRP*2*ORGNAME~
N3*ADDRESSLINE1*ADDRESSLINE2~
N4*CITY*ST*ZIPCODE~
LE*2120~
EB*D**********HC|91300~
DTP*472*D8*20210823~
LS*2120~
NM1*1P*2******XX*1234567893~
LE*2120~
EB*D**********HC|0003A~
DTP*472*D8*20210823~
LS*2120~
NM1*1P*2******XX*1987654323~
LE*2120~
EB*D**********HC|0002A~
DTP*472*D8*20210123~
LS*2120~
NM1*1P*2******XX*1987654323~
LE*2120~
EB*D**********HC|0001A~
DTP*472*D8*20201221~
LS*2120~
NM1*1P*2******XX*1987654323~
LE*2120~

EB*D**********HC|90630~
DTP*472*D8*20210101~
LS*2120~
NM1*1P*2******XX*1987654323~
LE*2120~
EB*D**********HC|G0008~
DTP*472*D8*20210101~
LS*2120~
NM1*1P*2******XX*1987654323~
LE*2120~
EB*D**********HC|99483~
DTP*472*D8*20220103~
LS*2120~
NM1*1P*2******XX*1234567893~
LE*2120~
EB*D**********HC|99483~
DTP*472*D8*20190101~
LS*2120~
NM1*1P*2******XX*1987654323~
LE*2120
SE*318*0001~
GE*1*1~
IEA*1*111111111~

Appendix C – Acronyms

Table 51 presents a list of acronyms used in this document.

Table 51. Acronyms

Acronym	Definition
ASC	Accredited Standards Committee
CMS	Centers for Medicare & Medicaid Services
CORE	Committee on Operating Rules for Information Exchange
CWF	Common Working File
DOB	Date of Birth
DOEBA	Date of Earliest Billing Activity
DOL	Date of Loss
DOLBA	Date of Latest Billing Activity
EDI	Electronic Data Interchange
ESRD	End Stage Renal Disease
HCPCS	Healthcare Common Procedure Coding System
HDT	HETS Desktop
HETS	HIPAA Eligibility Transaction System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HTTP	Hypertext Transfer Protocol
ICD	International Classification of Diseases
IP	Internet Protocol
IPPE	Initial Preventive Physical Exam
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MCARE	Medicare Customer Assistance Regarding Eligibility
MDPP	Medicare Diabetes Prevention Program
MIME	Multipurpose Internet Mail Extensions
MSP	Medicare Secondary Payer
NOA	Notice of Admission
NOE	Notice of Election
NPI	National Provider Identifier
ORM	Ongoing Responsibility for Medicals
Part B-ID	Part B Immunosuppressive Drug Benefit
POS	Point of Service
PPO	Preferred Provider Organization

Acronym	Definition
QMB	Qualified Medicare Beneficiary
RRB	Railroad Retirement Board
SNF	Skilled Nursing Facility
SOAP	Simple Object Access Protocol
STC	Service Type Code
TCP	Transmission Control Protocol
TPMS	Trading Partner Management System
TR3	ASC X12 270/271 Implementation Guide. Formerly known as the IG.
WSDL	Web Services Description Language
XML	Extensible Markup Language

Appendix D – Revision History

Table 52 provides a summary of changes made to this document.

Table 52. Document Revision History

Version	Date	Description of Changes
10-33.1	11/15/2023	Updated Sections 2.1, 3, and 5 to note that the MCARE Help Desk is closed on Federal holidays. A link to the OPM website that lists Federal holidays is provided.
10-33	08/17/2023	Changes include: Section 7.2 was updated to add Audiology HCPCS codes. Section 7.2 was also updated to describe Prior Authorization functionality. Footnote was added reminding HETS submitters that no more than 99 EQ segments can be submitted on a 270 request. Section 7.20 was updated to reflect the addition of an MSG segment with the ORM indicator value to the 271 MSP response. Section 7.27 was added to explain the way the 271 response returns audiology diagnostic testing information. Examples of the audiology eligibility response are included in this section. Table 33 was updated to reflect its potential use across a variety of supported HCPCS codes, including both preventive and audiology diagnostic services. Table 44 was updated to reflect the addition of an MSG segment with the ORM indicator value to the 271 MSP response. Table 50 was added to explain the way the 271 response returns Prior Authorization information. Subsequent tables were renumbered.
10-32	06/15/2023	Changes include: Section 7.20 was updated to clarify that the same 271 REF01 = ‘6P’, REF02 value can be used for either MSP Insurance Group Number or Date of Loss (DOL). Updated Reference Identification Qualifier in Table 44 to clarify that the 271 REF01 = ‘6P’, REF02 value can be used for either MSP Insurance Group Number or DOL.
10-31	05/19/2023	Changes include: Added footnote to section 7.20 for MSP Insurance Group Number. Updated Reference Identification Qualifier in Table 44 to include a series of zeroes for MSP Insurance Group Number.
10-30	05/12/2023	Changes include: Section 7.20 was updated to reflect the revised HETS 271 MSP response. HETS will additionally return MSP group number, last MSP maintenance date, the MSP source code (and text description of that code) and/or the MSP relationship code (and text description of that code) when available. Table 44 was updated to reflect the revised HETS 271 MSP response. Formatting changes throughout the document.
10-29	03/08/2023	Updated Section 4.3.2.1 to note a change in the types of DigiCert certificates that HETS accepts for SOAP and MIME connectivity. Updated Table 44 to remove MSP type ‘LT’ as a potential value that can be returned in the HETS 271 2110C EB04 for MSP. CMS has determined MSP type ‘LT’ is not a value that will be returned in the HETS 271.

Version	Date	Description of Changes
10-28	02/06/2023	Changes include: Section 7.16 was updated to reflect the revised HETS 271 Hospice response. HETS now returns all available Hospice Election and Hospice Benefit Period data (up to a maximum of fifty historic billed Benefit Periods). The HETS 271 response for Hospice also now includes Election Receipt Date and Revocation Dates when available. Handling logic for the Hospice Revocation Indicator (returned as an MSG segment) has also been updated. Table 40 was updated to reflect the 271 Hospice response changes including new possible values in the 2110C DTP02 element. Appendices A & B were updated to reflect 2023 dates and recent Hospice changes.
10-27	12/09/2022	Changes include: Section 7.2 was updated to note that requested Service Type Code(s) and or HCPCS code(s) will be returned as inactive coverage if the Medicare beneficiary is covered via the Part B Immunosuppressive Drug Benefit (Part B-ID). Section 7.5.1 was updated to include Part B Immunosuppressive Drug Benefit (Part B-ID) information. This section was also updated to reflect that HETS can return the most recent entitlement or enrollment reason code for each type of entitlement or enrollment. If a Medicare beneficiary has multiple benefit periods for the same entitlement or enrollment reason, then the entitlement/enrollment reason code only returns for the most recent period. Table 11 was retitled to 'Medicare Entitlement/Enrollment Reason Codes'. Changes were made throughout the document to reflect that the reason code can reflect either entitlement or enrollment records. Table 11 was also updated to include "P – Part B Immunosuppressive Drug Benefit" as a valid Medicare Entitlement/Enrollment Reason Code (and matching text description). Section 7.7.1 was updated to reflect that the 271 response will include Part B deductible and coinsurance information for Medicare beneficiaries with Part B-ID coverage. Section 7.7.2 was updated to reflect that HETS will return Part B financials for HCPCS when returning HCPCS information. Previously, HETS would not return Part B financials for HCPCS if the deductible and coinsurance amounts matched overall Part B financials. Section 7.10 was updated to include a link to Section 7.7.2 for additional information about Medicare Part B Preventive service financials. Section 7.15 was updated to clarify that ESRD Dialysis periods returned in the 271 are ESRD Clinical Dialysis periods Section 7.21 was updated to note that beneficiaries can be simultaneously enrolled in both Part B-ID and the QMB programs. Section 7.26 was added to explain the way the 271 response returns Part B Immunosuppressive Drug Benefit (Part B-ID) information. Examples of the Part B-ID eligibility response are included in this section. Table 25 was updated to reflect that beneficiaries that are enrolled in the Part B Immunosuppressive Drug Benefit (Part B-ID) will return Part B coverage only. Medicare Part A and Part D will return inactive coverage for these beneficiaries. All supported Service Type Codes or HCPCS Codes submitted on the 270 requests will return as inactive benefits on the HETS 271 response when the Medicare beneficiary is enrolled in Part B-ID for the requested Date(s) of Service. Table 39 was updated to clarify that ESRD Dialysis periods returned in the 271 are ESRD Clinical Dialysis periods. Appendix C (Acronyms) was updated to include Part B Immunosuppressive Drug Benefit (Part B-ID).

Version	Date	Description of Changes
10-26	05/04/2022	Changes include: Several tables were re-numbered Section 4.2.1 – Updated HETSHelp URL from http://go.cms.gov/hetshelp to https://cms.gov/hetshelp Section 7.9 was updated to note that the HETS 271 response for Home Health will return a Notice of Admission (NOA) when available Section 7.23 was updated to note that Acupuncture treatments are allotted on a rolling one year period instead of a calendar year Table 32 was updated to reflect HETS handling of the Home Health NOA when available Appendix C (Acronyms) was updated to include Notice of Admission (NOA)
10-25	02/02/2022	Changes include: Section 7.10.1 was updated to add Colorectal cancer screening HCPCS Code G0327 Section 7.10.2 was updated to add PPV HCPCS Codes 90671 and 90677 Section 7.24.2 was added to detail HETS handling of Influenza (Flu) Vaccination Section 7.25 was added to detail HETS handling of Cognitive Assessment and Care Plan services Table 31 was updated to reflect HETS handling of additional PPV HCPCS Codes 90671 and 90677 Table 41 was updated to clarify that HETS returns a 271 2110C EB01 of 'U' for Medicare Advantage Plans. CMS strongly recommends that Medicare Providers/Suppliers contact the Medicare Advantage plan directly to confirm the beneficiary's Medicare Advantage plan eligibility information Table 46 was updated to reflect HETS handling of Influenza (Flu) Vaccination Table 47 was added to detail HETS handling of Cognitive Assessment and Care Plan services Appendix C (Acronyms) updated to be Table 48 Appendix D (Revision History) updated to be Table 49
10-24	09/09/2021	Changes include: Section 4.3.2 was updated to document the recommendation that SOAP or MIME submitters who have a new Digital Certificate should contact MCARE to begin the process to transition to a new certificate at least 30 days prior to the expiration of the existing certificate. CMS and MCARE require adequate time to process and prepare the new certificate to ensure there is no service interruption. Section 7.24 was updated to include an example where HETS is returning three COVID-19 vaccine administration codes for a Medicare beneficiary. HETS will return the most recent instance of any/all COVID-19 vaccination information that is available on the Medicare beneficiary record.
10-23	04/14/2021	Section 7.24 was updated to reflect that the rendering NPI for prior COVID-19 immunization services will return on the HETS 271 response when available in upstream systems. Removed reference to April 2021 availability of prior COVID-19 immunization services.

Version	Date	Description of Changes
10-22	02/11/2021	Changes include: Section 7.2 – Removed STC 80 (Immunizations) from the list of STCs that return under Medicare Part A benefits. CMS has determined that COVID-19 immunizations are covered under Medicare Part B only. Updated to note that STC 80 financial liability is returned for the current year only. Clarified that STC 80 financials may be combined with other free services for current year, but previous years would not include STC 80. Section 7.5.1 – Removed STC 80 from the Part A entitlement example. Section 7.7.1 – Updated to note that STC 80 financial liability is returned for the current year only. Clarified that STC 80 financials may be combined with other free services for current year, but previous years would not include STC 80. Section 7.7.2 – Removed references to Medicare Part A. Updated to note that HETS only returns PPV Preventive Service HCPCS codes 90670 and/or 90732 if the Medicare beneficiary has active Medicare Part B entitlement at the time of the eligibility request. Section 7.10.2 – Removed references to Medicare Part A. Updated to note that HETS only returns PPV Preventive Service HCPCS codes 90670 and/or 90732 if the Medicare beneficiary has active Medicare Part B entitlement at the time of the eligibility request. Section 7.23 – Updated to more accurately describe the condition where the HETS 271 response would return zero remaining Acupuncture sessions. Section 7.24 – Removed references to Medicare Part A. COVID-19 immunization services are covered under Medicare Part B only. Clarified that STC 80 financials may be combined with other free services for current year, but previous years would not include STC 80. Table 26 – Removed references to Medicare Part A. Updated to note that HETS only returns PPV Preventive Service HCPCS codes 90670 and/or 90732 if the Medicare beneficiary has active Medicare Part B entitlement at the time of the eligibility request. Table 27 -- Removed references to Medicare Part A. Updated to note that HETS only returns PPV Preventive Service HCPCS codes 90670 and/or 90732 if the Medicare beneficiary has active Medicare Part B entitlement at the time of the eligibility request. Table 31 – Removed references to Medicare Part A. Updated to note that HETS only returns PPV Preventive Service HCPCS codes 90670 and/or 90732 if the Medicare beneficiary has active Medicare Part B entitlement at the time of the eligibility request. Table 45 -- Updated to more accurately describe the condition where the HETS 271 response would return zero remaining Acupuncture sessions. Appendix B – Updated STC 80 (Immunizations) plan level eligibility information to reflect that COVID-19 immunizations are covered under Medicare Part B only. Updated to reflect that STC 80 financials may be combined with other free services for current year, but previous years would not include STC 80.

Version	Date	Description of Changes
10-21	02/01/2021	Changes include: Section 7.2 – Updated to reflect that HETS returns the most recent Medicare Part A and Part B entitlement reason code and text if available for current coverage. Removed HCPCS code G0297 from the list of supported codes. Added STCs 64 (Acupuncture) and 80 (Immunizations) to the list of supported codes. Noted that HETS will return separate 271 2110C loops for COVID-19 immunization plan level eligibility when STC 80 submitted on the 270 request. Section 7.5.1 – Updated to reflect that HETS returns the most recent Medicare Part A and Part B entitlement reason code and text if available for current coverage. Noted that HETS will return separate 271 2110C loops for COVID-19 immunization plan level eligibility when STC 80 submitted on the 270 request. Section 7.19 – Updated all remaining 'MCO' references to 'MA', including that the MSG segment HETS returns for MA plan information will change its text from 'MCO' to 'MA'. Section 7.23 – Added to explain HETS handling of acupuncture services. Section 7.24 – Added to explain HETS handling of COVID-19 immunizations. Section 10.1 -- Removed HCPCS code G0297 from the list of supported codes. Table 23 – Updated to include MSG segment that can be returned to show current Medicare entitlement reason code and text. Noted that HETS will return separate 271 2110C loops for COVID-19 immunization plan level eligibility when STC 80 submitted on the 270 request, including new use of DTP01 value of '771'. Table 41 -- Updated to reflect that the 271 2110C MSG segment has changed its text from 'MCO' to 'MA'. Table 45 – Added to explain HETS handling of acupuncture services. Table 46 – Added to explain HETS handling of COVID-19 immunizations. Appendix B – Updated to reflect that the 271 may include an entitlement reason code. Updated to reflect that the 271 may include acupuncture services information. Updated to reflect that the 271 may include immunization information. Updated to reflect that the 271 2110C MSG segment has changed its text from 'MCO' to 'MA'. Updated to note that HETS will return separate 271 2110C loops for COVID-19 immunization plan level eligibility when STC 80 submitted on the 270 request.
10-20	12/18/2020	Changes include: Section 7.2 – Added code 71271 to the list of HETS supported codes effective 01/01/2021. Added notes to reflect that HCPCS code G0297 will be supported through 1/31/2021. Section 10.1 -- Added code 71271 to the list of HETS supported codes effective 01/01/2021. Added notes to reflect that HCPCS code G0297 will be supported through 01/31/2021.

Version	Date	Description of Changes
10-19	11/16/2020	Changes include: Section 1.1 – Updated URL reference to the X12.org website Section 1.3 – Updated URL reference to the X12.org website Section 4.3 – Updated URL references to CAQH CORE to reflect changes on the CAQH website. Section 4.3.2.2 – Updated Entrust URL Section 7.7.2 – Updated to note that HETS will not return Medicare Part B financial details on the 271 response for PPV Preventive Service HCPCS codes 90670 and/or 90732 if the Medicare beneficiary only has active Medicare Part A entitlement at the time of the eligibility request. Section 7.10.2 – Updated to add that PPV Preventive Services HCPCS codes 90670 and/or 90732 will return if the Medicare beneficiary has active Medicare Part A or Part B entitlement. Previously HETS only returned this information if the Medicare beneficiary has active Medicare Part B entitlement. Noted that PPV services delivered to beneficiaries while they are in a Medicare Advantage plan will not be included in the HETS 271 response. Table 26 – Updated to note that HETS will not return Medicare Part B Deductible details on the 271 response for PPV Preventive Service HCPCS codes 90670 and/or 90732 if the Medicare beneficiary only has active Medicare Part A entitlement at the time of the eligibility request. Table 27 -- Updated to note that HETS will not return Medicare Part B Coinsurance details on the 271 response for PPV Preventive Service HCPCS codes 90670 and/or 90732 if the Medicare beneficiary only has active Medicare Part A entitlement at the time of the eligibility request. Table 31 – Updated to add that PPV Preventive Services HCPCS codes 90670 and 90732 may return based on active Medicare Part A entitlement. Appendix C – Added CORE
10-18	08/17/2020	Changes include: Section 4.3.2.3 -- Removed this section as Symantec is no longer a CMS HETS Certificate Authority. Sections 4.3.2 – 4.3.4 – Updated the external link to the CAQH CORE Connectivity Rule to reflect changes on the CAQH website. Section 7.10 – Added bullet number three to clarify that Medicare coverage rules apply to all preventive service data returned in the HETS 271 response. Refer to Medicare coverage information for specific details on preventive service coverage. Section 7.16 – Updated to note that historic billed Hospice episodes are limited to the fifty most recent episodes. Also updated to note that effective with the R2020Q300 release, HETS will return enhanced data (Hospice DOEBA/DOLBA & Hospice Days Used) for up to fifty billed Hospice episodes that have occurred within the last four years. Table 38 – Updated to reflect addition of HSD loop (to illustrate Hospice Days Used for up to fifty billed Hospice episodes that have occurred within the last four years) and an additional supported 271 2110C DTP02 value (“435”) to illustrate Hospice DOEBA-DOLBA dates for up to fifty billed Hospice episodes that have occurred within the last four years.

Version	Date	Description of Changes
10-17	04/23/2020	Changes include: Section 7.2 – List of supported HCPCS updated to add G0476 Section 7.8 – Updated to note that the HETS 271 breaks applicable Part A Hospital/SNF spells into separate Hospital and SNF components, including the rendering NPI and specific stay dates. Section 7.9 – Updated to note that if available, the HETS 271 include the Home Health patient status code. An MSG segment would be returned that includes both the patient status code and its description. Section 7.10.1 – Updated to add Human Papillomavirus (HPV) to list of preventive services that return next eligible dates Section 7.16 – Added note that HETS 271 includes the Hospice NPI unless the NPI value on the database is invalid. In those situations, HETS does not return the rendering Hospice facility NPI. Table 28 – Updated to include data that the 271 response uses to differentiate between the larger Part A Hospital/SNF spell and the separate Hospital/SNF stays. Also updated to include NM1 loop used to return the rendering facility NPI for Hospital/SNF stays. Table 30 – Updated to include, if available, an MSG segment to return the Home Health patient status code.
10-16	02/06/2020	Changes include: Section 1.2 – Updated to reflect that HETS is now located in a virtual High Availability environment Refreshed SOAP/MIME implementation instructions for the HETS High Availability transition. Sections 4.3.2-4.3.4 and 8.5.3-8.5.5 were refreshed and revised Section 7.10 – Separated into two sub-sections (7.10.1 – Preventive HCPCS Codes Which Return Next Eligible Dates and 7.10.2 – Preventive HCPCS Codes Which Return Prior Service History). HETS will now return prior service history for HCPCS Codes 90670 and 90732 instead of next eligible dates and therefore are now covered in Section 7.10.2. All other supported preventive service HCPCS codes will continue to return next eligible dates (as outlined in Section 7.10.1) Table 31 – Updated to reflect that HETS can return preventive service prior service history include delivery date and rendering NPI. Updated the entire table and referred specific elements to either Section 7.10.1 or Section 7.10.2 as appropriate
10-15	11/26/2019	Changes include: Removing all references to the Health Insurance Claim Number (HICN). Effective 1/1/2020 HETS no longer accepts the HICN on 270 requests. Any 270 requests that include a HICN will receive no better than a 271 2100C AAA03 = “72” response for an invalid Member ID. Section 7.3 updated significantly to reflect these changes. The previous Table 10 (outlining HETS processing during the New Medicare Card transition period) was also removed and subsequent tables renumbered Section 7.5 – Separated into two sub-sections (7.5.1 – HETS 270/271 Business Rules and 7.5.2 – HETS Date of Death Business Rules) to improve readability. Added Figure 4 (Date of Death Business Rules) to Section 7.5.2 Section 7.16 – Updated to clarify that HETS utilizes the Hospice Revocation Code from any associated Notice of Election (NOE). Contiguous billed Hospice episodes associated with a single NOE will all return the Revocation Code from that NOE.

Version	Date	Description of Changes
10-14	07/31/2019	Changes include: Section 7.16 – Updated to reflect that 271 Hospice information returns all Hospice episodes or NOE regardless of the Date(s) of Service requested on the 270. Also noted that HETS no longer returns a Hospice Occurrence Count in the 271 response Section 7.22 – Updated to reflect possible return of a MDPP Period 2 end date for Medicare beneficiaries that have exhausted their MDPP eligibility Table 32 – Previous Table 32 (271 Part A Hospice Occurrence Count) removed from previous version. HETS no longer returns a Hospice Occurrence Count in the 271 response. Subsequent tables re-numbered Table 45. Updated to reflect possible return of a MDPP Period 2 end date for Medicare beneficiaries that have exhausted their MDPP eligibility Appendix B. Updated eligibility response example to include revised Hospice handling
10-13	02/19/2019	Changes include: Section 4.2.1 – Updated to reflect that HETS does not currently have a standing maintenance window. HETS is typically available 24 hours a day, 7 days a week. Table 6 – Added ISA09 and a clarifying note that HETS always expects a current date Section 7.2 – Added Service Type Code “RN” to the list of supported codes. Added code “G0499” to the list of supported HCPCS codes Section 7.10 – Added code “G0499” to list of supported preventive service HCPCS codes Section 7.11 – Updated to reflect revised handling of Smoking/Tobacco Cessation benefits on the 271 Section 7.15 – Updated to reflect revised handling of ESRD benefits on the 271 Table 32 – Updated note for 271 2110C EB10 element Table 34 – Updated to reflect revised handling of Smoking/Tobacco Cessation benefits on the 271 Table 39 – Updated to reflect revised handling of ESRD benefits on the 271
10-12	10/10/2018	Changes include: Section 7.16 – Added bullet to explain that HETS returns the date of the current Notice of Election (NOE) as the hospice period start date Section 7.18 – Updated to reflect revised handling of Part D Contract/PBP Information Section 7.19 – Updated to reflect revised handling of MA Contract/PBP Information Section 7.20 – Added bullet to explain that HETS will return any applicable diagnosis codes for the MSP enrollment period as an MSG segment. Multiple enrollment periods may result in multiple MSG segments (one per MSP enrollment) Section 7.22 – Updated to reflect that if eligible, HETS will return HCPCS codes detailing previous MDPP usage Table 42 – Updated to reflect revised handling of Part D Contract/PBP Information Table 43 – Updated to reflect revised handling of MA Contract/PBP Information Table 44 – Updated to reflect that HETS can return MSG segments which list any applicable diagnosis codes for the MSP enrollment period. Multiple enrollment periods may result in multiple MSG segments (one per MSP enrollment) Table 46 – Updated to reflect that if eligible, HETS will return HCPCS codes detailing previous MDPP usage Appendix C – Table 47. Added ICD and NOE
10-11	07/27/2018	Changes include: Section 7.2 – Reinstate HCPCS codes 90670 and 90732 to list of supported codes Section 7.10 – Reinstate PPV HCPCS codes to list of supported preventive service HCPCS codes

Version	Date	Description of Changes
10-10	07/12/2018	Changes include: Section 7.2 – Removed HCPCS codes 90670 and 90732 from list of supported codes Section 7.4 – Updated to reflect that HETS now accepts historical Date(s) of Service of up to 4 years. Bullet added to note that CMS recommends against defaulting to the maximum allowable date span. Table 11 updated to reflect the historical Date(s) of Service change Section 7.10 – Removed PPV HCPCS codes from list of supported preventive service HCPCS codes
10-9	06/27/2018	Changes include: Table 12 – Updated the cause of 271 2100C AAA03 = '72' responses Table 46 -- Modified the DTP02 element note to reflect that the date information returned in this loop is based on the 270 request Date(s) of Service. Updated MDPP Coinsurance loop to reflect that HETS returns a coinsurance Percentage (EB08) instead of coinsurance Monetary Amount (EB07). In any case, authorized MDPP services require zero deductible or coinsurance
10-8	04/26/2018	Changes include: Removed all references to the 4/1/2018 beginning of the New Medicare Card transition period Section 7.2 – Added Service Type Code "CQ" to the list of supported codes Section 7.3 – Added bullet to explain that, if applicable, HETS returns an MBI's end date on the 271 response if the Date(s) of Service overlaps the terminated MBI's effective period. Updated this section to reflect that HETS will not return cross-referenced MBI values Section 7.5 – Updated to reflect the MDPP benefit information is returned in a separate eligibility loop than other STCs Section 7.10 – Updated to reflect that if HETS does not return preventive HCPCS codes 90670 or 90732, then the Medicare beneficiary has already received these one-time services Section 7.15 – Updated to reflect that Service Type Code "CQ" will return ESRD information (if applicable) Section 7.19 – Updated to reflect that HETS returns a different 271 2110C EB03 value of "30^CQ" if STC "CQ" is included in the 270 request (and all other data creates a match) Section 7.22 – Added to document to explain MDPP support Table 22 – Modified to reflect that HETS will, if applicable, return a 271 2100C DTP01 value of '"52" when indicating that a MBI has an end date. Updated to reflect that HETS will not return cross-referenced MBI values Table 39 – Updated to reflect that Service Type Code "CQ" will return ESRD information (if applicable) Table 43 – Added 271 2110C EB03 details Table 46 – Added to detail eligibility information for MDPP services Appendix C – Table 47. Added MDPP Minor grammatical and formatting updates throughout the document

Version	Date	Description of Changes
10-7	02/07/2018	Changes include: Section 7.19 – Updated to reflect that HETS returns a 271 2110C EB01 of 'U' for Medicare Advantage Plans. CMS strongly recommends that Medicare Providers/Suppliers contact the Medicare Advantage plan directly to confirm the beneficiary's Medicare Advantage plan eligibility information Table 12 – Updated the cause of 271 2100A AAA03 = '42' responses Table 43 -- Updated to reflect that HETS returns a 271 2110C EB01 of 'U' for Medicare Advantage Plans. CMS strongly recommends that Medicare Providers/Suppliers contact the Medicare Advantage plan directly to confirm the beneficiary's Medicare Advantage plan eligibility information Appendix A – Updated sample transaction to include 2018 Dates of Service Appendix B – Added a loop to the 271 response to illustrate HETS returning a Medicare beneficiary ineligible for a specific IPPE HCPCS code. Updated sample transaction to include 2018 Dates of Service. Updated sample transaction to reflect that HETS now returns a 271 2110C EB01 of 'U' for Medicare Advantage Plans Minor grammatical and formatting updates throughout the document
10-6	11/13/2017	Changes include: Sections 1.4.2 - 1.4.3 – Updated to indicate that HETS will process either a HICN or MBI value effective April 1, 2018 Section 7.2 – Removed HCPCS code G0202 from list of supported codes. Removed note which stated that HCPCS code 77067 should not be sent prior to 01/01/2018. Section 7.3 – Updated to include New Medicare Card transition period. Added Table 10 to explain HETS handling of HICN and MBI during the transition period. Section 7.10 – Removed HCPCS code G0202 from list of supported codes. Removed note which stated HCPCS code 77067 should not be sent prior to 01/01/2018. Tables 12, 19 & 22 – Updated to indicate that HETS will process either a HICN or MBI value effective April 1, 2018 Appendices A & B – Updated 270 & 271 examples to include a MBI being sent in the 270 request and a MBI being returned in the 271 response. Appendix C – Table 45. Added 'MBI' Minor grammatical and formatting updates throughout the document
10-5	11/07/2017	Changes include: Section 7.8 – Updated sample Hospital/SNF loops to reflect that HETS will return the 2110C EB06 value of '26' for Full Days Co-Payment amount. HETS previously returned '7' as the 2110C EB06 for both Full Days Co-Payment amount. HETS will still return the 2110C EB06 as '7' for Hospital/SNF Coinsurance Co-Payment amount Section 7.21 – Updated sample QMB Hospital/SNF loops to reflect that HETS has uncoupled the Hospital/SNF Full Days and Coinsurance Days from a single EB loop into separate EB loops. The EB06 of the Hospital/SNF Full Days Co-Payment amount also changed from '7' to '26' Table 29 – Updated to reflect change of 2110C EB06 value from "7' to '26' for Hospital/SNF Full Days Co-Payment amount Appendix B – Updated sample 271 response to reflect change of 2110C EB06 value from '7' to '26' for Hospital/SNF Full Days Co-Payment amount Minor grammatical and formatting updates throughout the document

Version	Date	Description of Changes
10-4	10/12/2017	Changes include: Section 1.2 – Added note to indicate that questions about QMB eligibility should be directed to State online Medicaid eligibility systems or other documentation Section 7.2 – Added HCPCS codes 77067, 81528, G0297, G0442, G0443, G0472, G0473 and G0475 to the list of HETS supported HCPCS codes. Added notes to reflect that code G0202 will no longer be effective 01/01/2018 and that code 77067 would only become effective 01/01/2018. Added bullet to indicate that HETS will return hospital spell DOEBA-DOLBA for all spells that intersect the calendar year(s) of the date request regardless of STC or HCPCS code present on the 270 Section 7.6 – Updated to reflect that HETS will return all Part A Free Services date(s) within a single 271 2110C loop EB segment with the potential for multiple DTP segments. Also updated 271 2110C DTP segment example to reflect that for 100% covered Part A services, HETS will return dates within a calendar year where no QMB enrollment is present Section 7.7.1 – Updated to reflect that HETS will return all Part B Free Services date(s) within a single 271 2110C loop EB segment with the potential for multiple DTP segments. Also updated 271 2110C DTP segment example to reflect that for 100% covered Part A services, HETS will return dates within a calendar year where no QMB enrollment is present Section 7.7.2 – Significant rewrite to this section to reflect changes included in this release, including QMB related changes Section 7.8 – Updated 271 2110C DTP segment examples to illustrate that HETS will return dates within a calendar year where no QMB enrollment is present Section 7.10 – Updated to include descriptions of new HETS supported HCPCS codes. Added note to explain that HETS may return IPPE preventive codes as ineligible. Added note to reflect that code G0202 will no longer be effective 01/01/2018 and that code 77067 would only become effective 01/01/2018. Added bullet to mention that HETS will not return preventive service financial details for beneficiaries whose QMB Period lasts the entire year Section 7.16 – Updated to note that Hospice Occurrence Count will only be returned if the Medicare beneficiary has Part A Entitlement Section 7.21 – Added to detail situations where HETS will return QMB Periods Tables 24-27 – Updated to add details related to handling of QMB Periods Table 28 – Added new table to illustrate how HETS will return a hospital DOEBA-DOLBA for all spells that intersect the calendar year(s) of the date request regardless of STC or HCPCS code present on the 270. Subsequent tables renumbered Table 29 – Updated to add details related to handling of QMB Periods Table 31 – Added 271 table to reflect HETS returning Part A Hospice Occurrence Count Table 32 – Updated to reflect that HETS can return IPPE HCPCS codes as ineligible services Table 42 – Removed reference to HETS returning Baltimore, MD address information on behalf of the MA Plan if no plan address information is available Table 43 – Added new MSP code AP for No-Fault Medicare Set-Aside Arrangement (NFSMA) and new MSP code LT for Liability Medicare Set-Aside Arrangement (LMSA) Table 44 – Added new table to detail 271 response for QMB Periods. Subsequent tables renumbered Appendix A & B – Updated sample transactions to more current examples Appendix C – Table 45. Added ‘QMB’ and ‘IPPE’ Minor grammatical and formatting updates throughout the document
10-3	08/24/2017	Changes include: Updated the linked address in Section 4.2.1 to reflect an updated URL. Section 7.20 – Updated the description of the MSP Policy Number to clarify that the returned number is the group coverage plan in which the Medicare beneficiary is enrolled. Similar changes noted in Section 10.2, Table 41, and Appendix B

Version	Date	Description of Changes
10-2	12/05/2016	Changes include: Section 7.2 – Added HCPCS code 76706 to and removed HCPCS codes 77057 and G0389 from the list of HETS supported codes. HCPCS code 77057 is being removed from the list of supported codes effective 01/01/2017. HCPCS code 76706 is replacing HCPCS code G0389 effective 01/01/2017 Section 7.10 – Updated the seventeenth bullet in this section to reflect the removal of HCPCS code 77057 effective 01/01/2017. Updated the final bullet in this section to reflect the HCPCS code change of G0389 to 76706 effective 01/01/2017
10-1	06/21/2016	Changes include: Section 4.2.1 – Updated HETSHelp URL from http://www.cms.gov/HETSHelp to the new URL of http://go.cms.gov/hetshelp Section 7.2 – Added note that HETS will return a 999 error when a request is submitted with a dependent loop Section 10.2, Table 19 – Removed 2100A PER loop. HETS will no longer return a 2100A PER loop in each 271 response Appendix B – Removed 2100A PER loop from the sample response. HETS will no longer return a 2100A PER loop in each 271 response

Version	Date	Description of Changes
10-0	02/23/2016	Changes include: Section 1.3 – Updated to include reference to the HETS Trading Partner SOAP/MIME Connectivity Instructions Section 1.4 – Mentioned that repetitive sending of the same transaction in a single day is an aberrant behavior that will be monitored Section 4.3.1 – Figure 3 updated to include more current sample data Section 4.3.2 – Removed references to December 31, 2015 deadline to utilize TLS 1.2 and a SHA2-256 certificate as this deadline has passed Section 4.3.2.2 – Updated list of Entrust digital certificate types accepted by HETS Section 4.3.3.4 – Updated to reflect that the SOAP specific URL is available in the HETS Trading Partner SOAP/MIME Connectivity Instructions Section 4.3.3.6 – Tables 2-5 updated to include updated W3C URL. Tables 3 & 5 updated to include proper Payload Type code for TA1 situations. Titles of Tables 3 & 5 also updated Section 4.3.4.1 – Updated to reflect that the MIME specific URL is available in the HETS Trading Partner SOAP/MIME Connectivity Instructions Section 7.2 – Noted that the HETS 271 database is only updated once per day, therefore Trading Partners should not submit the same transaction multiple times per day expecting to receive updated results. Also added note that “child” components of STC 1, 30, 35, 47 and/or MH will not be returned when the Medicare beneficiary is ineligible. Also added note with restrictions as to when STC 48 & 49 are not returned in the 271 response Section 7.3 – Added note that submitting a beneficiary Middle Name or Initial in 270 2100C NM105, a Gender Code in 270 2100C DMG03 or a value of ‘SY’ in 270 2100C REF01 will result in a 999 response. Added general note that Trading Partners should not send additional beneficiary data elements outside of items listed in Table 9. HCPCS code 90669 removed from the list of supported HCPCS codes Section 7.5 – Added clarifying notes regarding how HETS responds to supported STCs when the Medicare beneficiary is deceased and the Date of Death is prior to the requested Date(s) of Service Section 7.10 – HCPCS code 90669 removed from the list of supported Preventive HCPCS codes Section 7.11 – Removed previous 2nd bullet stating that HETS will return a separate 2110C loop when STC 67 is submitted on the request for a deceased Medicare beneficiary Section 7.12 – Added clarifying note to 3rd bullet Section 8.3 – Table 11 updated to reflect new AAA code “T4” and modified error message code descriptions for AAA03 04, 79, 41, 43, 51 and 72 reject reason code descriptions Section 8.4 – Tables 12 & 13 updated to reflect changes to Proprietary Error handling Section 8.5.2 – Table 14 updated to reflect new and updated Error Codes and Error Messages Section 8.5.3 – Table 15 updated to add a new Error Code and Error Message while deleting all previous Error Codes and Error Messages Section 8.5.4 – The previous Table 16 (MIME-Specific Processing Errors) was deleted. HETS will no longer return MIME-specific processing errors Section 10.1.3 – Table 19. Added notes specifying maximum allowable length for Subscriber Last Name and Subscriber First Name Section 10.2 – Table 22. Added note that HETS will return ‘MISSING’ in the 2100C NM109 if there is no HICN submitted in the 270 request Appendix C – Table 42. Added HDT/HETS Desktop Minor grammatical and formatting updates throughout the document including consistently using the term ‘Trading Partner’ in lieu of ‘Submitter.” Also updated sample data throughout the document to more current examples.

Version	Date	Description of Changes
9-4	08/25/2015	Changes include: Section 4.3 – Updated section including changing TLS version to 1.1 (and moving to TLS 1.2 in 2015), requiring SHA2-256 encryption in 2015, updating links to CAQH.org webpages, and updating the list of approved digital certificates in Section 4.3.2.
9-3	04/27/2015	Changes include: Section 1.4 – Added note clarifying that the HETS 270/271 application is not a claims processing or appeals system Section 2.2 – Added a direct link to the HETS 270/271 Trading Partner Agreement form Section 4.1.1 & Figure 1 – Updated to include reference to the annual HETS Trading Partner Recertification process Section 4.2.1 –Removed reference to the HETS Status website while adding link to the HETS Help website. Figure 3 – Updated TCP/IP Communication Transport Protocol Wrapper example to better match structure of a current HETS 270 request Table 3 & 5 – Updated description of the 271 ReceiverID field Section 7.1 – Added specific reference to X12 00510X231 TR3 Section 7.2 – Reorganized section. Clarified date(s) of service rule relevant to child STCs. Removed note that HETS will return a 999 error when a request is submitted with a dependent loop. Added notes defining STC and HCPCS acronym definitions. Section 7.7.1 – Removed Mental Health Coinsurance Percentage bullet and sample data Section 7.8 – Added bullet to describe condition where overlapping Hospital spells may occur due to changes in Medicare beneficiary primary entitlement coverage Section 7.11 – Updated bullet to clarify business rules Section 8.2 – Added specific reference to X12 005010X231 TR3 Table 11 – Updated AAA03=52 Error to clarify that HETS 270/271 may require an overnight update after a new Submitter ID/NPI relationship is created in HPG Table 11 – Updated AAA03=62 Error condition to reflect searches beyond 12 months historical (previously 27 months historical) Table 13 – Removed a Proprietary Error code (HTS00106) that is no longer valid Updated hyperlinks throughout the document Table 23 – Update to reflect that HETS will return address information as Unknown if the address of file is missing or invalid Table 40 – Update to reflect that HETS will return address information as Unknown if the address of file is missing or invalid Table 41 – Update to reflect that HETS will return address information as Unknown if the address of file is missing or invalid Appendix A & B – Updated sample transactions to more current examples Minor grammatical and formatting updates throughout the document

Version	Date	Description of Changes
9-2	7/11/2014	Changes include: Section 4.2.1 – Updated hyperlink from the HETS Help index to the HETS Help Spotlight Section 4.3 – Updated section to include reference to the HETS SOAP/MIME Connectivity document Section 4.3.2.4 – Updated note to include reference to payload information in Table 2 Section 7.1 – Update section to include mention that CMS will return a standard set of delimiters on each 271 response regardless of the delimiters sent in the 270 request Section 7.4 – Updated supported historical Date of Service search from 27 months to 12 months to allow HETS to mirror the Medicare Fee-for-Service timely filing requirements that were enacted under the Patient Protection and Affordable Care Act (PPACA) in 2010 Section 7.6 – Updated DOEBA/DOLBA bullet to include +/- 60 days Section 7.9 – Updated to note that HETS will now return the Home Health Contractor number when the Home Health Contractor name is not available Section 7.16 – Updated to note that Medicare beneficiary must have Part A Entitlement for Hospice information to be returned in the 271 response Section 8.1 – Updated to reflect that HETS returns a TA1 when the Trading Partner is not actively authorized to use HETS 270/271 Section 8.3 – Updated Table 11 to include new 2100A AAA03 = '04' error code. This condition currently returns a 999 error Section 9.0 – Updated to include reference to the annual Trading Partner Agreement recertification requirement Table 19 – Updated 2110C EQ01&02 note/comment to remove reference to STC 30 and include reference to Section 7.2 Tables 33-36 – Updated in-table 2110C EB comment to correct section reference names Table 37 – Corrected EB04 note/comment to properly note that STC 15 returns MA while STC 14 returns MB Table 41 – Updated 2120C N3 & N4 loops to reflect change in address information that will be returned if a MA plan address information is incomplete in the CMS plan database. Updated hyperlinks throughout the document
9-1	1/14/2014	2014Q100 Changes include: Section 7.2 and 7.10-Updated with Bone Density codes Updated examples throughout Section 7, Appendix A and B
9-0	12/30/2013	Updates for X12 verbiage
8-1	10/15//2013	Changes include: Table 31- Added new HH+H numbers 06001, 06014 Table 27 and Section 7.7.1- Updated DTP to be 291 for Plan Level Part B Coinsurance.

Version	Date	Description of Changes
8-0	7/18/2013	2013Q400 Changes include: Section 2.2- Updated wording Figure2- Removed URLs Table 2 and 4 - Updated Sender ID and payload Section 4.3 - Updated wording Section 7.2- Updated bullets for coinsurance Table 10- Updated the example Section 7.6- Updated the examples Section 7.7.1 – Updated bullets for coinsurance Section 7.8 – Updated for psych data and updated examples Section 7.16 – Updated for Hospice Occurrences and updated examples Table 27 and 30 – Updated EB03 Table 31- Added new HH+H numbers 06004, 14014 Table 39 –Updated for Hospice Occurrence Updated Appendix A and B for Coinsurance, Psych data and Hospice Occurrence
7-4	4/30/2013	Corrected delimiter in Appendix A example
7-3	04/08/2013	Changes include: Section 7.2- Updated the bullets for STC= 30.
7-2	04/1/2013	Changes Include: Section 7.2 – Added bullets for HCPCS, updated “child” component bullet for DOD. Section 7.5 – Updated EB01 = “6” bullet and example. Section 7.7 – Updated for HCPCS financials business rules. Section 7.10 – Removed G0442/0443 and added bullet for modifier and Professional/Technical Section 7.11 – Added bullet for base/remaining sessions = 8 Table 22 – Updated address elements for missing data. Added new tables 28 and 29 for HCPCS Deductible and Coinsurance information. Appendix A and B – Updated the 270/271 examples.
7-1	03/06/2013	Changes include: Section 4.3.2.4 – Updated URL for SOAP transactions. Section 4.3.3.1 – Updated URL for MIME transactions.
7-0	02/15/2013	Changes include: Section 1.2 – Updated to include internet protocols. Section 4.1.2 – Added Transaction Process for all communication protocols. Section 4.3 – Updated section and added sub-sections for SOAP and MIME. Section 4.4 – Updated for SOAP and MIME. Section 7.7 – Updated example for percentage format. Section 7.9 and Table 30 – Replaced colon with pipe for HC|G0180 and HC|G0179. Section 8.3 – Removed text reference to AAA code 74 since it was removed from the table in a previous release. Section 8.5 – Added section for SOAP and MIME errors. Table 29 – Corrected DTP01 code value for the Lifetime Benefit Reserve EB Loop