

HIPAA 270/271 Transactions & Code Sets

*Companion guide to the
HIPAA X12 Implementation Guide
(version 005010X279A1)*

Disclosure Statement

This Companion Guide is issued in an effort to provide Trading Partners of CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., collectively known as “CareFirst,” with the most up-to-date information related to standard transactions. Any and all information in this guide is subject to change at any time without notice. Each time you test or submit a standard transaction, we recommend that you refer to the most recently posted Companion Guide to ensure you are using the most current information available.

Preface

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with CareFirst. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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1. Introduction

Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Secretary of the Department of Health and Human Services (HHS) is directed to adopt standards to support the electronic exchange of administrative and financial health care transactions. The purpose of the Administrative Simplification portion of HIPAA is enable health information to be exchanged electronically and to adopt standards for those transactions.

1.1 Scope

This companion guide is intended for CareFirst Trading Partners interested in exchanging HIPAA compliant X12 eligibility information (270/271 transactions) with CareFirst. It is intended to be used **in conjunction with** X12N Implementation Guides and is not intended to contradict or exceed X12 standards. It contains information about specific CareFirst requirements for processing the 270/271 X12 transactions.

All instructions in this document are written using information known at the time of publication and are subject to change. The most current version of the guide is available online at carefirst.com/electronicclaims.

1.2 Overview

This Companion Guide is issued in an effort to provide the CareFirst trading partners with the most up-to-date information related to standard transactions. Any and all information in this guide is subject to change at any time without notice.

This Companion Guide is applicable to all lines of business within CareFirst.

This document is designed to assist both technical and business areas of trading partners who wish to exchange HIPAA standard 270/271 transactions with CareFirst, Inc. It contains specifications for the transactions, contact information, and other information that is helpful.

All instructions in this document are written using information known at the time of publication and will change as necessary to provide the most up-to-date information. The most up-to-date version of the Companion Guide is available online at carefirst.com/electronicclaims.

CareFirst is not responsible for the performance of software outside of its installations.

1.3 References

This companion guide is an adjunct to the **National Electronic Data Interchange Transaction Set Implementation Guide Health Care Eligibility Benefit Inquiry and Response 270/271 ASC X12N (005010X279A1)**.

1.4 Additional information

Please be sure to always use the most current version of the companion guide available online at carefirst.com/electronicclaims.

Always feel free to contact CareFirst as described in Section 5.

2. Getting Started

2.1 Working with CareFirst

CareFirst accepts X12 standard transactions from any HIPAA covered entity with which it has an agreement. Please see section 2.2 for location of existing Trading Partners

2.2 Trading partner registration

CareFirst accepts electronic transaction from selected trading partners. Medical trading partners are listed online at provider.carefirst.com/providers/claims/medical-electronic-capabilities. page.

Dental trading partners are listed online at provider.carefirst.com/providers/dental/claims-submission.page.

New partners are added via invitation every 5 years. If you are interested in being contacted for the next invitation to bid, please send an email to edirectsubmission@carefirst.com.

2.3 Testing & certification overview

CareFirst requires all potential submitters to participate in testing to ensure that transactions produce the desired results. CareFirst supplies the test data and access information to the test system. Successful completion and validation is an indication that all systems can properly submit and receive the transactions.

2.4 Production status

The EDI Operations Support Group will advise the new submitter when all conditions are satisfied and submission of production transactions can begin. At that time a production certificate of trust will be issued by CareFirst to the trading partner.

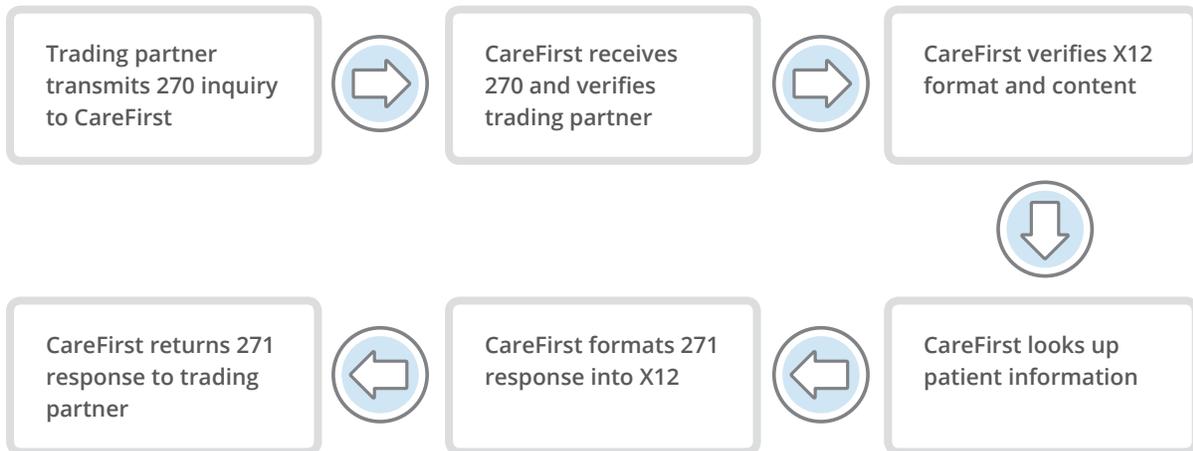
3. Testing

CareFirst requires all potential submitters to participate in testing to ensure that transactions produce the desired results. Successful completion and validation is an indication that all systems can properly submit and receive the transactions.

Security is verified with a certificate of trust attached to each transaction and verification of submitting IP address(es). CareFirst will provide a certificate of trust to the submitting trading partner. A separate certificate will be available for testing. A production certificate will be issued at the successful completion of testing. The trading partner must provide the IP address(es) used for both testing and production submission of transactions.

4. Connectivity/Communications

4.1 Process flows



The above illustrates the basic flow of the 270 Inquiry and 271 Response transactions.

4.2 Transmission administrative procedures

4.2.1 Schedule, availability and downtime notification

CareFirst production systems are available 24 hours per day, 7 days per week with the exception of 1:00 AM EST through 9:00 AM EST each Sunday for the real-time processing mode. There are no regularly scheduled downtimes except as indicated in the prior statement. CareFirst Systems' planned downtime will be communicated to all Trading Partners via an email message sent at least one week prior to the event. The following is an example of the message to be sent to announce planned downtime.

To: Trading Partners
From: CareFirst B2B Gateway
The CareFirst B2B Gateway will be unavailable on xx/xx/xxxx from x AM to x PM for scheduled maintenance.
This outage will affect the following transactions: 270/271, 276/277. We apologize for any inconvenience.

CareFirst Systems' unplanned downtime will be communicated to Trading Partners by email as soon as possible. A second email will be dispatched when the system becomes available.

To: Trading Partners
From: CareFirst B2B Gateway
The CareFirst B2B Gateway is unavailable at this time due to a system outage.
This outage affects the following transactions: 270/271, 276/277. We apologize for any inconvenience.
A follow-up email will be sent when the system is once again available.

4.2.2 Re-transmission procedures

When a 270 inquiry transaction receives a reject code by CareFirst it must be corrected and re-submitted by the provider.

4.3 Communication protocol specifications

CareFirst receives and transmits transactions using HTTP/S.

4.4 Passwords

Logon and passwords are replaced by the use of security certificates and verification of submitting IP addresses. The Trading Partner must submit the certificate supplied by CareFirst with every transaction. There are separate certificates for test and production.

CareFirst security is maintained on three levels:

1. Verification of a certificate of trust attached to each transaction
2. Verification of the IP address submitting the transaction (supplied by the submitter)
3. Verification of the Trading Partner Id (in the ISA segment) supplied by CareFirst.

5. CareFirst Contact Information

5.1 EDI customer service

All inquiries and comments regarding initiation, set-up, testing, and submission of HIPAA transactions should be directed to EDIdirectsubmission@carefirst.com.

Support for all EDI Transactions is provided by the HelpDesk during normal business hours at 877-526-8390 or at EDIdirectsubmission@carefirst.com.

5.2 EDI technical assistance

All inquiries and comments regarding initiation, set-up, testing, and submission of HIPAA transactions should be directed to EDIdirectsubmission@carefirst.com.

Support for all EDI Transactions is provided by the HelpDesk during normal business hours at 877-526-8390 or at EDIdirectsubmission@carefirst.com.

5.3 Provider service number

All inquiries and comments regarding initiation, set-up, testing, and submission of HIPAA transactions should be directed to EDIdirectsubmission@carefirst.com.

Support for all EDI Transactions is provided by the HelpDesk during normal business hours at 877-526-8390 or at EDIdirectsubmission@carefirst.com.

5.4 Applicable web-sites/email

All inquiries and comments regarding initiation, set-up, testing, and submission of HIPAA transactions should be directed to EDIdirectsubmission@carefirst.com.

Support for all EDI Transactions is provided by the HelpDesk during normal business hours at 877-526-8390 or at EDIdirectsubmission@carefirst.com.

The most current version of this companion guide is available online at carefirst.com/electronicclaims > *Guides*.

6. Control Segments/Envelope

6.1 ISA-IEA

6.1.1 The 270 eligibility/benefit inquiry

This section describes the values required by CareFirst in the ISA and IEA segments.

IG Page	Reference	X12 Element Name	Length	Valid Values/Notes/Comments
C.4	ISA01	Authorization Information Qualifier	2	Must be "00"
C.4	ISA03	Security Information Qualifier	2	Must be "00"
C.4	ISA05	Interchange ID Qualifier	2	Must be "ZZ"
C.4	ISA06	Interchange Sender ID	15	Must be trading partner ID
C.5	ISA07	Interchange ID Qualifier	2	Must be "ZZ"
C.5	ISA08	Interchange Receiver ID	15	Must be CareFirst ID
C.5	ISA09	Interchange Date	6	Must be YYMMDD
C.5	ISA10	Interchange Time	4	Must be HHMM
C.5	ISA11	Interchange Control Standards Identifier	1	Must be "^"
C.5	ISA12	Interchange Control Version	5	Must be "00501"
C.5	ISA13	Interchange Control Number	9	9 digit unique number with a non- zero in the first position. ISA13 must be identical to IEA02.
C.6	ISA14	Acknowledgement Indicator	1	Must be "0"
C.6	ISA15	Usage Indicator	1	Must be "T" or "P" NOTE: test system rejects P; production system rejects T.
C.6	ISA16	Component Element Separator	1	Must be ":"
C.10	IEA01	Number of included Functional Groups	1/5	Must be "1"
C.10	IEA02	Interchange Control Number	9/9	IEA02 must be identical to ISA13

6. Control Segments/Envelope

6.1.2 The 271 response

This section describes the values returned by CareFirst in the ISA and IEA segments.

IG Page	Reference	X12 Element Name	Length	Valid Values/Notes/Comments
B.3	ISA01	Authorization Information Qualifier	2	"00"
B.4	ISA03	Security Information Qualifier	2	"00"
B.4	ISA05	Interchange ID Qualifier	2	"ZZ"
B.4	ISA06	Interchange Sender ID	15	CareFirst ID
B.4	ISA07	Interchange ID Qualifier	2	"ZZ"
B.5	ISA08	Interchange Receiver ID	15	Trading partner ID
B.5	ISA09	Interchange Date	6	YYMMDD
B.5	ISA10	Interchange Time	4	HHMM
B.5	ISA11	Interchange Control Standards Identifier	1	"^"
B.5	ISA12	Interchange Control Version	5	"00501"
B.5	ISA13	Interchange Control Number	9	ISA13 will be identical to IEA02
B.6	ISA14	Acknowledgement Indicator	1	"0"
B.6	ISA15	Usage Indicator	1	"T" or "P"
B.6	ISA16	Component Element Separator	1	Must be ":"
B.7	IEA01	Number of included Functional Groups	1/5	"1"
B.7	IEA02	Interchange Control Number	9/9	IEA02 will be identical to ISA13

6. Control Segments/Envelope

6.2 GS-GE

6.2.1 The 270 eligibility/benefit inquiry

This section describes the values required by CareFirst in the GS segment.

IG Page	Reference	X12 Element Name	Length	Valid Values/Notes/Comments
B.8	GS01	Functional Identifier Code	2/2	Must be "HS"—Eligibility Coverage or Benefit Inquiry
B.8	GS02	Application Sender's Code	2/15	Must be trading partner ID. Trading partner ID must be appended with "R" for this element only.
B.8	GS03	Application Receiver's Code	9	CareFirst ID
B.8	GS04	Date	8/8	CCYYMMDD
B.9	GS05	Time	4/8	HHMMSS or HHMMSSD or HHMMSSDD
B.9	GS06	Group Control Number	1/9	The functional group control number in GS06 must be identical to data element 02 of the GE segment
B.9	GS07	Responsible Agency Code	1/2	Must be "X"
B.9	GS08	Version/ Release/ Industry Identifier Code	1/12	Must be "005010X279A1"
B.10	GE01	Number of Transaction Sets Included	1/6	Must be "1"
B.10	GE02	Group Control Number	1/9	The functional group control number in GE02 must be identical to data element 06 of the GS segment.

6.2.2 The 271 response

This section describes the values returned by CareFirst in the GS and GE segments.

IG Page	Reference	X12 Element Name	Length	Valid Values/Notes/Comments
C.7	GS01	Functional Identifier Code	2/2	"HB"—Eligibility Coverage or Benefit Information
C.7	GS02	Application Sender's Code	2/15	CareFirst ID
C.7	GS03	Application Receiver's Code	9	Trading partner ID appended with "R"
C.7	GS04	Date	8/8	CCYYMMDD
C.8	GS05	Time	4/8	HHMMSS
C.8	GS06	Group Control Number	1/9	The functional group control number in GS06 must be identical to data element 02 of the GE segment.
C.8	GS07	Responsible Agency Code	1/2	"X"
C.8	GS08	Version/ Release/ Industry Identifier Code	1/12	"005010X279A1"
C.9	GE01	Number of Transaction Sets Included	1/6	"1"
C.9	GE02	Group Control Number	1/9	The functional group control number in GE02 must be identical to data element 06 of the GS segment.

6. Control Segments/Envelope

6.3 ST-SE

6.3.1 The 270 eligibility/benefit inquiry

CareFirst requires standard HIPAA values in the ST and SE segments.

IG Page	Reference	X12 Element Name	Length	Valid Values/Notes/Comments
61	ST01	Transaction Set Identifier Code	3/3	Must be "270"
61	ST02	Transaction Set Control Number	4/9	The transaction set control numbers in ST02 and SE02 must be identical.
62	ST03	Implementation Convention Reference	1/35	Must be "005010X279A1"
200	SE01	Number of Included Segments	1/10	Count of data segments including ST and SE Segments. In the event when this count does not match the exact number of data segments, a 997 is generated.
200	SE02	Transaction Set Control Number	4/9	The transaction set control numbers in ST02 and SE02 must be identical.

6.3.2 The 271 response

CareFirst returns standard HIPAA values in the ST and SE segments.

7. CareFirst Business Rules and Limitations

7.1 Real time processing mode

CareFirst supports only real time 270 inquiry and 271 response transactions.

7.2 Single patient inquiry

A real time transaction is limited to one patient per inquiry. Inquiries from dental trading partners will return dental policies; inquiries from medical trading partners will return medical policies.

7.3 EQ segment

CareFirst supports Medical Trading Partner inquiry at the Service Type Level (EQ01). CareFirst does not recommend inquiry at the Procedure Code level (EQ02). In an event when an inquiry at the Procedure Code or Procedure/ Diagnosis Code Level is received, CareFirst will return a Baseline Service Type 30 Response.

Only the first EQ segment is processed for a response if multiple EQ Segments are received within the 270 inquiry or to a single inquiry when there are multiple occurrences of EQ01.

In the examples below only Service Type Code '98' will be processed. Inquiry including Multiple EQ segments:

EQ*98~

EQ*34~

EQ*44~

EQ*81~

EQ*A0~

EQ*A3~

OR

Inquiry including a Single EQ segment with Repetition Function:

EQ*98^34^44^81^A0^A3~

Dental trading partner Inquiries support either the service type in EQ01 or the ADA procedure code in EQ02.

7.4 DTP segment

The criteria for Dates of Service are as follows:

1. Date has to be within the last calendar year.
2. It cannot surpass the end of the current month.
3. If a date range is received, the 'From date' will be used for processing and the 'To date' will be ignored.

7.5 Error conditions

1. A TA1 acknowledgement is returned when there is a transmission or envelope error (other than a timeout).
2. A 999 acknowledgement is returned when there is a HIPAA or an X12 compliance error. The Trading Partner should correct the error and resubmit the 270 transaction.
3. A 271 with an AAA segment is returned when there is a data error or when the system is unavailable. The Trading Partner should correct the error and resubmit the 270 transaction.
4. Error conditions found on the 270 request that shall generate a 271 response containing an AAA Segment with error codes are listed on the following table. Note the list is not limited to AAA error codes generated locally, but also include AAA codes that may be returned by another Blue Plan. Please refer to the table on Page 29 for CareFirst specific codes.

AAA message table

Condition	AAA01 Code and Meaning	AAA03 Reason Reject Code and Meaning	AAA04 Follow up Action Code and Meaning
Membership number is not on file (subscriber request)	N—No	72—Invalid subscriber ID	C—Please correct and resubmit
Membership number is not on file (dependent request)	N—No	64—Invalid patient ID	C—Please correct and resubmit
Missing patient date of birth	N—No	58—Invalid/missing date of birth	C—Please correct and resubmit
Patient date of birth does not match that for the patient on the database	N—No	71 - Birth date does not match file	C—Please correct and resubmit
System down	Y—Yes	42- Unable to respond at this time (system down)	R—Resubmission allowed
Provider is ineligible	N—No	50—Provider ineligible	C—Please correct and resubmit
Date of service is not within the last calendar year or surpasses the end of the current month	Y—Yes	62—Date not within allowable period	C—Please correct and resubmit
Missing subscriber name or subscriber name is not a match	Y—Yes N—No	73—Invalid/missing subscriber/insured name	C—Please correct and resubmit
Missing patient name or patient name is not a match	Y—Yes N—No	65—Invalid/missing patient/insured name	C—Please correct and resubmit
Missing gender	Y—Yes N—No	66—Invalid/missing gender	C—Please correct and resubmit
Batch/real time mode conflict	Y—Yes	80—No response received; transaction terminated	R—Resubmission allowed

7.6 Multiple policies

If more than one active policy exists for a member, only one is returned.

When requested by dental trading partners, the ACA dental pediatric policy always takes precedence over any other policy.

8. Acknowledgements and/or Reports

The submitter of a 270 in real-time will receive only one acknowledgement/response from CareFirst: a TA1 (error); a 999 (error); or a 271.

The TA1 Interchange Acknowledgement is used to indicate a rejection (aka a negative acknowledgement) of the ISA/IEA Interchange containing the 270 Eligibility Benefit Inquiry Request.

If the 270 passes ISA/IEA compliance checking, but an error is found during the validation of the Functional Group(s) or Transaction Set(s) within a Functional Group, a 999 Functional Acknowledgement indicates a rejection (negative acknowledgement). If there are no errors a 999 is not returned.

If the 270 complies with the X12 standard syntax requirements, then the 271 Eligibility Inquiry Response is returned to the submitter.

The AAA segments in the 271 are used to report business level error situations.

8.1 Report inventory

There are no reports regarding the 270/271 transactions available to trading partners.

9. Trading Partner Agreements

9.1 Trading partners

All inquiries and comments regarding trading partner relationships with CareFirst should be addressed by contacting CareFirst using the information in Section 5.

10. Transaction Information

10.1 The 270 eligibility/benefit inquiry

This section describes the standard HIPAA values required by CareFirst in the BHT segment.

IG Page	Reference	X12 Element Name	Length	Valid Values/Notes/Comments
63	BHT01	Hierarchical Structure Code	4	Must be "0022"
64	BHT02	Transaction Set Purpose Code	2	Must be "13"
64	BHT03	Reference Identification	1/50	This identifier will be returned in the corresponding 271 transaction's BHT03
64	BHT04	Date	8/8	CCYYMMDD
65	BHT05	Time	4/8	HHMM or HHMMSS or HHMMSSD or HHMMSSDD

If BHT06 element is received, 270 will process without this element. CareFirst 270/271 do not support Medicaid programs.

This section describes the values required by CareFirst in the HL segments.

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
67	2000A	HL01	Hierarchical ID number	Must be "1"	1/12	Initial HL segment
67	2000A	HL02	Hierarchical Parent ID number	Must be missing		
67	2000A	HL03	Hierarchical Level Code	Must be "20"	1/2	Information source
68	2000A	HL04	Hierarchical Child Code	Must be "1"	1/1	Additional subordinate HL data segment in this hierarchical structure
73	2000B	HL01	Hierarchical ID number	Must be "2"	1/12	This number is incremented by one for each successive occurrence of the HL segment
73	2000B	HL02	Hierarchical Parent ID number	Must be "1"		
74	2000B	HL03	Hierarchical Level Code	Must be "21"	1/2	Information receiver
74	2000B	HL04	Hierarchical Child Code	Must be "1"	1/1	Additional subordinate HL data segment in this hierarchical structure
88	2000C	HL01	Hierarchical ID number	Must be "3"	1/12	This number is incremented by one for each successive occurrence of the HL segment
88	2000C	HL02	Hierarchical Parent ID number	Must be "2"		
89	2000C	HL03	Hierarchical Level Code	Must be "22"	1/2	Subscriber

10. Transaction Information

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
89	2000C	HL04	Hierarchical Child Code	Must be "1" OR "0"	1/1	Must be "1" when patient is dependent; "0" when subscriber is the patient
147	2000D	HL01	Hierarchical ID number	Must be "4"	1/12	This loop must be used only when the patient is a dependent of a member
148	2000D	HL02	Hierarchical Parent ID number	Must be "3"	1/12	
148	2000D	HL03	Hierarchical Level Code	Must be "23"	1/2	Dependent
148	2000D	HL04	Hierarchical Child Code	Must be "0"	1/1	

This section describes the values required by CareFirst in the NM1 segments.

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
69	2100A	NM101	Entity Identifier Code	Must be "PR"	2	Payor
70	2100A	NM102	Entity Type Qualifier	Must be "2"	1	Non-person entity
70	2100A	NM103	Last Name or Organization Name	Must be "CareFirst BlueCross BlueShield"	1/60	
71	2100A	NM108	Identification Code Qualifier	Must be "PI"	2	
71	2100A	NM109	Information Source Primary Identifier		6	BCBS plan code "080" or "190" CareFirst will accept any of the allowable values listed above
75	2100B	NM101	Entity Identifier Code	Must be "1P"	2	Provider
76	2100B	NM102	Entity Type Qualifier	Must be "2"		
77	2100B	NM108	Identification Code Qualifier	Must be "XX"	2	National Provider Identifier
78	2100B	NM109	Information Receiver Primary Identifier		2/80	Must be provider's National Provider ID
80	2100B	REF01	Entity Type Qualifier	Enter "TJ"	2/3	Tax ID qualifier
80	2100B	REF02	Reference Identification	Enter tax ID	1/50	Provider tax ID May be submitted at the sender's discretion
92	2100C	NM101	Entity Identifier Code	Must be "IL"	2	Insured or subscriber
93	2100C	NM102	Entity Type Qualifier	Must be "1"		
93	2100C	NM103	Last Name		1/60	Required only when subscriber is the patient
93	2100C	NM104	First Name		1/35	Required only when subscriber is the patient
94	2100C	NM105	Middle Name		1/25	Submit if available for a subscriber
95	2100C	NM108	Identification Code Qualifier	Must be "MI"	2	Member identification number

10. Transaction Information

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
96	2100C	NM109	Subscriber Primary Identifier		3/17	CareFirst member/subscriber ID; including 1–3 character alphanumeric prefix shown on ID card Two ways that IDs can be sent: 1) ABC123456789 2) 123456789 A valid format for FEP membership is R followed by 8 numeric characters. Example: R12345678 Member ID suffix must not be submitted
114	2100D	NM101	Entity Identifier Code	Must be "03"	2	Dependent
115	2100D	NM102	Entity Type Qualifier	Must be "1"		Person
115	2100D	NM103	Last Name		1/60	Required when dependent is the patient
115	2100D	NM104	First Name		1/35	Required when dependent is the patient
115	2100D	NM105	Middle Name		1/25	Submit if available for a dependent

This section describes the values required by CareFirst in the TRN segment. TRN Segment may appear only at the subscriber or dependent level. CareFirst strongly suggests the use of Transaction Trace Number (TRN) segments on ANSI 270 transactions. These TRN segments will be echoed on the ANSI 271 response.

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
90 & 149	2000C or 2000D	TRN01	Trace Type Code	Must be "1"	1/2	Current transaction trace number 1. TRN segment in 2000C loop may be assigned if the subscriber is the patient. 2. TRN segment in 2000D loop may be assigned if the Dependent is the patient. 3. TRN segment will be moved from 2100C to 2100D if requested subscriber on 270 is returned as the dependent in the 271 response and vice versa.
91 & 150	2000C or 2000D	TRN02	Reference Identification		1/50	
91 & 150	2000C or 2000D	TRN03	Originating Company Identifier		10/10	

I 10. Transaction Information

This section describes the values required by CareFirst in the DMG segment. DMG Segment may appear only at the subscriber or dependent level.

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
108 & 165	2100C or 2100D	DMG01	Date Time Period Format Qualifier	Must be "D8"	2/3	Date expressed in CCYYMMDD
108 & 165	2100C or 2100D	DMG02	Date Time Period	CCYYM MDD	1/35	Patient date of birth 1. In an event that DMG segment is not received then AAA Error Code may be generated 2. In an event when a unique match is not identified with the submitted date of birth, AAA Error will be generated
109 & 166	2100C or 2100D	DMG03	Gender	F or M	1/1	1. Gender is optional on the 270 but recommended for better eligibility match 2. Any other value other than F or M submitted on 270 will generate a 999 3. Patient gender will always be returned on the 271

This section describes the values required by CareFirst in the DTP segment. DTP Segment may appear only at the subscriber or dependent level.

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
123 & 179	2100C or 2100D	DTP01	Date/Time Qualifier	Must be "291"	3	Plan
123 & 180	2100C or 2100D	DTP02	Date Time Period Format Qualifier	Must be D8 or RD8	3	Date expressed in CCYYMMDD. When "RD8" is sent as a qualifier CareFirst will use the From Date as DOS to search for eligibility. The Through Date is ignored.
123 & 180	2100C or 2100D	DTP03	Date Time Period		35	1. If this element is missing, then current date is used as DOS to search for eligibility 2. When "RD8" is sent, DTP03 must be a date range 3. In the event when "RD8" is sent as a qualifier and a single date is reported on DTP03, a 999 is generated

10. Transaction Information

10.2 The 271 Response

The following describes the CareFirst utilization of segments and elements when there is some type of uniqueness or restriction. All other values comply with HIPAA regulations.

This section describes the values returned by CareFirst in the NM1 segments.

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
218	2100A	NM101	Entity Identifier Code	"PR"	2	Payor
219	2100A	NM102	Entity Type Qualifier	"2"	1	
219	2100A	NM103	Entity Description		30	"CareFirst BlueCross BlueShield"
220	2100A	NM108	Identification Code Qualifier	"PI"	2	
220	2100A	NM109	Information Source Primary Identifier		6	"080" or "190" CareFirst will respond on the 271 response with the same Plan Code received on the 270 request
232	2100B	NM101	Entity Identifier Code	"1P" (provider) or "80" (hospital) or "FA" (facility) or "GP" (gateway provider)	2	From the 270
234	2100B	NM108	Identification Code Qualifier	"XX"	2	Health Care Financing Administration National Provider Identifier
235	2100B	NM109	Information Receiver Primary Identifier		2/80	Provider's National Provider ID from the 270
251	2100C	NM108	Identification Code Qualifier	"MI"	2	Member identification number

This section describes the values returned by CareFirst in the REF segment.

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
237	2100B	REF01	Reference Identification Qualifier	"TJ"	2/3	Reference Identification Qualifier
237	2100B	REF02	Reference Identification		1/50	Federal Taxpayer's Identification number
254 and 358	2100C/2100D	REF01	Reference Identification Qualifier	"18"	2/3	Plan number
254 and 360	2100C/2100D	REF02	Reference Identification		1/50	One of the following: 080—National Capitol Area (DC) 190—Maryland FEP—Federal Employee Program OOA—Out of Area TZF- Facets 580—DC NASCO 690—Maryland NASCO

10. Transaction Information

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
254 and 358	2100C/2100D	REF01	Reference Identification Qualifier	"6P"	2/3	Group number
254 and 360	2100C/2100D	REF02	Reference Identification		1/50	
255 and 358	2100C/2100D	REF01	Reference Identification Qualifier	"EJ"	2/3	Patient account number
256 and 360	2100C/2100D	REF02	Reference Identification		1/50	CareFirst will return the REF segment at the subscriber level if 270 request contained a REF segment with a patient account number

If the 270 request specifies a particular service type in EQ01 (Service Type Code), the eligibility and benefit information in the 271 EB Segment(s) returned pertain to that service type. A response to a service type can contain references to multiple services covered/coinsured by CareFirst that pertain to the requested service type.

If the 270 request specifies a service type of "60" (General Benefits) in EQ01 (Service Type Code), only patient demographic and active/inactive medical status is returned in the EB Segment.

If the 270 request specifies a service type of "30" (Health Benefit Plan Coverage) in EQ01 or if the service type requested is not supported, the following information is returned on the EB Segment(s):

1. The patient's eligibility status for service types that are covered.
2. The Co-pay, coinsurance and base contract deductible amounts (in and out of network) for the covered services.

If the 270 request specifies a certain service code with specific procedure code, CareFirst will quote the benefit for the service level code.

There can be multiple MSG segments in every response.

There can be multiple EB segments. This section lists Deductible—Accumulated, Out-of-pocket Maximums—Static/Accumulated, Benefit Limitations—Accumulated information returned by CareFirst in the EB segment.

When a Dental Trading Partner request is returned with an FEP, CFA or Out of Area member, the EB01 will contain a V (cannot process) with the MSG01 "Currently unable to support Dental requests for this member."

10. Transaction Information

Deductible Name	Description	EB01 Eligibility Info	EB02 Coverage Level	EB03 Service Type	EB06 Time Qualifier	EB07 Amount	EB12 In-Network Indicator
In network: Individual	Yearly static value dollar amount that the patient owes as an individual	C (Deductible)	IND (Individual)	30 (Health Benefit Plan Coverage)	Will be populated with the value that applies to the deductible	present	Y
	Dollar amount remaining in order for the individual deductible to be satisfied	C (Deductible)	IND (Individual)	30 (Health Benefit Plan Coverage)	29 (Remaining)	present	Y
Out of network: Individual	Yearly static value dollar amount that the patient owes as an individual deductible	C (Deductible)	IND (Individual)	30 (Health Benefit Plan Coverage)	Will be populated with the value that applies to the deductible	present	N
	Dollar amount remaining in order for the individual deductible to be satisfied	C (Deductible)	IND (Individual)	30 (Health Benefit Plan Coverage)	29 (Remaining)	present	N
In network: Family	Yearly static value dollar amount that the patient owes as a family deductible (if applicable)	C (Deductible)	FAM (Family)	30 (Health Benefit Plan Coverage)	Will be populated with the value that applies to the deductible	present	Y
	Dollar amount remaining in order for the family deductible to be satisfied	C (Deductible)	FAM (Family)	30 (Health Benefit Plan Coverage)	29 (Remaining)	present	Y
Out of network: Family	Yearly static value dollar amount that the patient owes as a family deductible (if applicable)	C (Deductible)	FAM (Family)	30 (Health Benefit Plan Coverage)	Will be populated with the value that applies to the deductible	present	N
	Dollar amount remaining in order for the family deductible to be satisfied	C (Deductible)	FAM (Family)	30 (Health Benefit Plan Coverage)	29 (Remaining)	present	N

10. Transaction Information

	EB02	EB03	EB06	EB07	EB12
C	IND and FAM	30 Health Benefit Plan Coverage	Deductible Period Code (for static)	Deductible Amount	Y (in network) and N (out of network), or Omit as applicable
C	IND and FAM	30 Health Benefit Plan Coverage	29 (for remaining)	Remaining Deductible Amount	Y (in network) and N (out of network), or Omit as applicable

Description	EB01 Eligibility Info	EB02 Coverage Level	EB03 Service Type	EB06 Time Qualifier	EB07 Amt	EB12 In-Network Indicator
Yearly static value dollar amount that represents the individual out-of-pocket maximum	G (Out of Pocket)	IND (Individual)	30 (Health Benefit Plan Coverage)	Will be populated with the period value that applies to the out-of-pocket maximum	present	Y
Dollar amount remaining in order for the individual out-of-pocket maximum to be satisfied	G (Out of Pocket)	IND (Individual)	30 (Health Benefit Plan Coverage)	29	present	Y
Yearly static value dollar amount that represents the individual out-of-pocket maximum	G (Out of Pocket)	IND (Individual)	30 (Health Benefit Plan Coverage)	Will be populated with the period value that applies to the out-of-pocket maximum	present	N
Dollar amount remaining in order for the individual out-of-pocket maximum to be satisfied	G (Out of Pocket)	IND (Individual)	30 (Health Benefit Plan Coverage)	29	present	N
Yearly static value dollar amount that represents the family out-of-pocket maximum	G (Out of Pocket)	FAM (Family)	30 (Health Benefit Plan Coverage)	Will be populated with the period value that applies to the out-of-pocket maximum	present	Y
Dollar amount remaining in order for the family out-of-pocket maximum to be satisfied	G (Out of Pocket)	FAM (Family)	30 (Health Benefit Plan Coverage)	29	present	Y

10. Transaction Information

Description	EB01 Eligibility Info	EB02 Coverage Level	EB03 Service Type	EB06 Time Qualifier	EB07 Amt	EB12 In-Network Indicator
Yearly static value dollar amount that the patient owes as a family deductible (if applicable)	G (Out of Pocket)	FAM (Family)	30 (Health Benefit Plan Coverage)	Will be populated with the period value that applies to the out-of-pocket maximum	present	N
Dollar amount remaining in order for the family deductible to be satisfied	G (Out of Pocket)	FAM (Family)	30 (Health Benefit Plan Coverage)	29	present	N

Out of Pocket segments will be formatted using these data elements: EB01, EB02, EB03, EB06, EB07, EB12.

The following segments and data elements will be used to format static and remaining out-of-pocket data:

G	IND and FAM	30 Health Benefit Plan Coverage	Out of Pocket Period Code (for static)	Out of Pocket Maximum Amount	Y (in network) and N (out of network), or Omit as applicable
G	IND and FAM	30 Health Benefit Plan Coverage	29 (for remaining)	Remaining Out of Pocket Maximum	Y (in network) and N (out of network), or Omit as applicable

Plans will also return appropriate HSD segments as applicable to the benefit design. HSD01–HSD08 show detailed benefit limit usage patterns.

HSD01	HSD02	HSD03	HSD04	HSD05	HSD06	HSD07	HSD08
Quantity Qualifier	Quantity	Unit or basis for measurement code	Quantity	Time Period	Number of periods	Delivery of Calendar Pattern Code	Time Period

This section describes the values returned by CareFirst in the INS segment.

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
271 & 376	2100C or 2100D	INS01	Yes/No condition or reason code	"Y" OR "N"	1/1	A "Y" value indicates the insured is a subscriber; an "N" value indicates a dependent.
272 & 376	2100C or 2100D	INS02	Individual Relationship code	18, 01, 19, 20, 21, 39, 40, 53, G8	2/2	18 Self 01 Spouse 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner G8 Other Relationship

10. Transaction Information

IG Page	Loop ID	Reference	X12 Element Name	Codes	Length	Valid Values/Notes/Comments
272 & 376	2100C or 2100D	INS03	Maintenance Type code	"001"	3/3	CareFirst will return this element (and code "25" in INS04) if any subscriber identifying elements have been changed from those submitted in the 270.
272 & 377	2100C or 2100D	INS04	Maintenance Reason code	"25"	2/3	CareFirst will return this element (and code "001" in INS03) if any of the identifying elements for the subscriber have been changed from those submitted in the 270.

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Appendix A

Implementation checklist

CareFirst has four Preferred Trading Partners—RealMed, Siemens (HDX), Allscripts (Meddata) and Emdeon for the 270/271 Eligibility Transaction. Please contact one of our preferred vendors to submit 270 transaction to CareFirst.

Appendix B

CareFirst 271 AAA error codes

This is the list of codes that will be returned for CareFirst local members. Please refer to Table 1. AAA Message Table under Section 6.4 Error Conditions of this Companion Guide for conditions when each may be generated.

Error Codes & Description	
42	unable to respond at this time (system down)
43	invalid provider id
50	provider ineligible
57	invalid date of service
58	invalid birth date
60	birth date after date of service
62	date not within allowable period
64	invalid patient id
65	invalid patient name
66	invalid gender
67	patient not found
71	birth date does not match file
72	invalid subscriber id
73	invalid subscriber name
74	invalid subscriber gender
75	subscriber not found
80	no response received

HIPAA 271 AAA error codes

The list below includes all HIPAA allowable AAA Error codes. The list below includes all HIPAA allowable AAA error codes and returned from other Blues Plans when the member is out of area or Nasco. CareFirst will forward a 271 response containing these AAA Error code to the Trading Partner without altering the response as per BCBSA rules:

Error Codes & Descriptions	
04	too many patient requests
15	missing data
41	not authorized
42	unable to respond at this time (system down)
43	invalid provider id
44	invalid provider name
45	invalid provider specialty
46	invalid provider phone #
47	invalid provider state
48	invalid referring provider id
49	invalid primary care provider
50	provider ineligible
51	provider not on file
52	invalid service dates
53	invalid benefit type
54	invalid product id qualifier
55	invalid product id
56	invalid date
57	invalid date of service
58	invalid birth date
60	birth date after date of service
61	death precedes date of service
62	date not within allowable period
64	invalid patient id
65	invalid patient name
66	invalid gender
67	patient not found
68	duplicate patient id number

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Error Codes & Descriptions	
69	inconsistent with patient's age
70	inconsistent with patient's gender
71	birth date does not match file
72	invalid subscriber id
73	invalid subscriber name
74	invalid subscriber gender
75	subscriber not found

Error Codes & Descriptions	
76	duplicate subscriber number
77	patient not found
78	subscriber not in group
79	information source invalid
80	no response received
97	invalid provider address
T4	payer name missing

Appendix C

CareFirst supported service types

270 Provider Requests	271 Provider Receives (at minimum)	
EQ01 Service Type Request	EB03 Service Type(s) Response	Liability Summary
1 Medical Care	1 Medical Care*** 2 Surgical 42 Home Health Care 45 Hospice 69 Maternity 76 Dialysis 83 Infertility AG Skilled Nursing Care BT Gynecological BU Obstetrical DM Durable Medical Equipment***	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits ***For these codes, CareFirst returns Active/Non-Covered only.
2 Surgical	2 Surgical 7 Anesthesia 8 Surgical Assistance 20 Second Surgical Opinion	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
4 Diagnostic X-Ray	4 Diagnostic X-Ray	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
5 Diagnostic Lab	5 Diagnostic Lab	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
6 Radiation Therapy	6 Radiation Therapy	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
7 Anesthesia	7 Anesthesia	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
8 Surgical Assistance	8 Surgical Assistance	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
12 Durable Medical Equipment Purchase	12 Durable Medical Equipment Purchase	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
13 Ambulatory Service Center Facility	13 Ambulatory Service Center Facility	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
18 Durable Medical Equipment Rental	18 Durable Medical Equipment Rental	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
20 Second Surgical Opinion	20 Second Surgical Opinion	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits

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270 Provider Requests	271 Provider Receives (at minimum)	
30 Health Benefit Plan Coverage	1 Medical Care*** 33 Chiropractic 35 Dental Care**** 47 Hospital 48 Hospital Inpatient 50 Hospital Outpatient 51 Hospital—Emergency Accident 52 Hospital—Emergency Medical 86 Emergency Services 88 Pharmacy**** 98 Professional Visit Office—Physician 98 Professional (Physician) Visit—Office MSG01="SPECIALIST" AL Vision/Optometry**** BZ Professional Visit Office—Well MH Mental Health*** UC Urgent Care	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits ***For these codes we return Active Only, we do not return Liability. We omit if non-covered **** For these codes we return Active at a minimum and omit if non-covered
33 Chiropractic	4 Diagnostic X-Ray 33 Chiropractic	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
35 Dental Care	35 Dental Care	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
38 Orthodontics	38 Orthodontics	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
40 Oral Surgery	40 Oral Surgery	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
42 Home Health Care	42 Home Health Care A3 Professional (Physician) Visit—Home	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
45 Hospice	45 Hospice	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
47 Hospital	47 Hospital 51 Hospital—Emergency Accident 52 Hospital— Emergency Medical 53 Hospital—Ambulatory Surgical	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
48 Hospital—Inpatient	48 Hospital—Inpatient 99 Professional (Physician) Visit—Inpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
50 Hospital—Outpatient	50 Hospital Outpatient 51 Hospital—Emergency Accident 52 Hospital— Emergency Medical A0 Professional (Physician) Visit—Outpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
51 Hospital—Emergency Accident	51 Hospital—Emergency Accident	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
52 Hospital—Emergency Medical	52 Hospital—Emergency Medical	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
53 Hospital—Ambulatory Surgical	53 Hospital—Ambulatory Surgical	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
60 General Benefits	60 General Benefits	Active/Non-Covered only
61 In-vitro Fertilization	61 In-vitro Fertilization	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
62 MRI/CAT Scan	62 MRI/CAT Scan	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits

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270 Provider Requests	271 Provider Receives (at minimum)	
65 Newborn Care	65 Newborn Care	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
68 Well Baby Care	68 Well Baby Care 80 - Immunizations BH - Pediatric	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
69 Maternity	69 Maternity	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
73 Diagnostic Medical	73 Diagnostic Medical 4 Diagnostic X-Ray 5 Diagnostic Lab 62 MRI/CAT Scan	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
76 Dialysis	76 Dialysis	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
78 Chemotherapy	78 Chemotherapy	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
80 Immunizations	80 Immunizations	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
81 Routine Physical	81 Routine Physical	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
82 Family Planning	82 Family Planning	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
83 Infertility	83 Infertility 61 In-vitro Fertilization	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
84 Abortion	84 Abortion	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
86 Emergency Services	86 Emergency Services 51 Hospital—Emergency Accident 52 Hospital—Emergency Medical 98 Professional (Physician) Visit—Office	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
88 Pharmacy	88 Pharmacy	Active/Inactive (at Minimum)
93 Podiatry	93 Podiatry	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
98 Professional (Physician) Visit—Office	98 Professional (Physician) Visit—Office BZ Professional Visit Office—Well 98 Professional (Physician) Visit—Office with MSG01 = 'SPECIALIST'	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
99 Professional (Physician) Visit—Inpatient	99 Professional (Physician) Visit—Inpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
A0 Professional (Physician) Visit—Outpatient	A0 Professional (Physician) Visit—Outpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
A3 Professional (Physician) Visit—Home	A3 Professional (Physician) Visit—Home	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
A6 Psychotherapy	A6 Psychotherapy***	*** For these codes, we return Active/Non-Covered at a minimum
A7 Psychiatric— Inpatient	A7 Psychiatric—Inpatient***	***For these codes, we return Active/Non-Covered at a minimum
A8 Psychiatric—Outpatient	A8 Psychiatric—Outpatient***	***For these codes, return Active/Non-Covered at a minimum
AD Occupational Therapy	AD Occupational Therapy	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
AE Physical Medicine	AE Physical Medicine	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits

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270 Provider Requests	271 Provider Receives (at minimum)	
AF Speech Therapy	AF Speech Therapy	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
AG Skilled Nursing Care	AG Skilled Nursing Care	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
AI Substance Abuse	AI Substance Abuse	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
AL Vision (Optometry)	AL Vision (Optometry)	Active/Inactive (at Minimum)
BG Cardiac Rehabilitation	BG Cardiac Rehabilitation	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
BH Pediatric	BH Pediatric	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
BT Gynecological	BT Gynecological	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
BU Obstetrical	BU Obstetrical	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
BV Obstetrical/Gynecological	BV Obstetrical/Gynecological*** BT Gynecological BU Obstetrical	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits *** For this code, we only return Active/ Non-Covered
BY Physician Visit Office—Sick	BY Physician Visit Office—Sick	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
BZ Physician Visit Office—Well	BZ Physician Visit Office—Well	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CE MH Provider—Inpatient	CE MH Provider—Inpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CF MH Provider—Outpatient	CF MH Provider—Outpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CG MH Provider Facility—Inpatient	CG MH Provider Facility—Inpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CH MH Provider Facility—Outpatient	CH MH Provider Facility—Outpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CI Substance Abuse Facility—Inpatient	CI Substance Abuse Facility—Inpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CJ Substance Abuse Facility—Outpatient	CJ Substance Abuse Facility—Outpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CK Screening X-ray	CK Screening X-ray	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CL Screening Laboratory	CL Screening Laboratory	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CM Mammogram, HR Patient	CM Mammogram, HR Patient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CN Mammogram, LR Patient	CN Mammogram, LR Patient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits
CO Flu Vaccination	CO Flu Vaccination	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulated benefits

270 Provider Requests	271 Provider Receives (at minimum)	
DM Durable Medical Equipment	DM Durable Medical Equipment *** 12 Durable Medical Equipment Purchase 18 Durable Medical Equipment Rental	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulators *** For this code, we only return Active/ Non-Covered
MH Mental Health	MH Mental Health*** CE MH Provider—Inpatient CF MH Provider—Outpatient CG MH Provider Facility—Inpatient CH MH Provider Facility—Outpatient	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulators *** For this code, we only return Active/ Non-Covered
PT Physical Therapy	PT Physical Therapy	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulators
UC Urgent Care	UC Urgent Care	Co-insurance, deductible, co-pay, benefit limits, place of service, accumulators

Appendix D

Definitions, acronyms and abbreviations

The following is a list of key terms commonly associated with the Health Insurance Portability and Accountability Act (HIPAA).

BOL	Business Objects Layer
CMDB	Common Member Data Base
DDE	Direct Data Entry
EDI	Electronic Data Interchange
FEP	Federal Employee Program
HWS	HIPAA Web Services
IACS	Inquiry, Analysis and Control System
NPI	National Provider Identification number
XML	Extensible Markup Language
270	The patient eligibility request transaction
271	The patient eligibility response transaction
999	The X12 transaction to notify a Trading Partner when there is a format problem with an incoming (270) request
B2B Services Gateway	Carefirst access point for electronic commerce
CARE	Claims processing system used for MD claims

FEPOC	Federal Employee Program Operations Center It is the central location where all FEP claims must be sent in order to receive responses/answers to claims that have been billed/ processed by FEP adjudicators
FLEXX	Claims processing system used for DC Commercial and FEP claims
FACETS	Future claims processing system for commercial business
FEP Thin	.FCC (FEP Claims Centralization) It is the level below the pipeline that contains touchpoints (pricer, ODS, claimcheck, etc) for FEP processing prior to sending those claims to the FEPOC
Nasco InterAct	Future claims processing system for national and Bluecard business
HIPAA	Health Insurance Portability Accountability Act of 1996
Accredited Standards Committee (ACS)	ACS is an organization accredited by the American National Standards Institute (ANSI) for the development of American National Standards
Accredited Standards Committee X12 (ASC X12)	ASC X12 is a group accredited by the American National Standards Institute (ANSI) that defines electronic data interchange (EDI) standards for many American industries, including health care insurance

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Accredited Standards Committee X12N (ASC X12N)	ASC X12N is a subcommittee of X12 that defines electronic data interchange (EDI) standards for the insurance industry, including health care insurance
American National Standards Institute (ANSI)	ANSI is an organization that accredits various standards-setting committees, and monitors their compliance. HIPAA prescribes that, whenever practical, ANSI-accredited bodies develop mandated standards.
Implementation Guide (IG)	IGs are documents explaining the proper use of a standard for a specific business purpose. The X12N HIPAA IGs are the primary reference documents used by those implementing the associated transactions and are incorporated into the HIPAA regulations by reference
TA1	The X12 transaction to notify a Trading Partner when there is an interchange problem
X12	A standard transmission protocol and data format used for EDI transactions
XML	Extensible Markup Language
Contract Level	The subscriber level

Network Level	The network which the provider participates in (example POS or HMO)
Service Level	Any restrictions, maximums of limitations on the service type including but not limited to maximum dollar per year, provider type to perform service, number of hours service allowed per day, age limits
Out-of-Pocket	OOP is based upon the CareFirst payment to 100% where the plateau is based upon a combination of member responsibility which would mean deductible amounts and/or coinsurance and/or copayments
Static Deductible	The deductible amount to be met every year as stated in the benefit booklet
Static Out-of-Pocket	The out-of-pocket amount to be met every year as stated in the benefit booklet
Stop Loss	Stop Loss is based upon the CareFirst payment changing to 100% where the plateau is based upon the total of eligible expenses before payment is calculated, but after the deductible is subtracted

Appendix E Change summary

The following chart includes the summary of changes made to the Companion Guide.

Companion Document Change Summary				
Date	Version	Status	Page	Description
12/18/12	Version 1.1	Addition		Updates have been made to incorporate the CORE Companion Guide Template Rule changes
05/01/2016	Version 2.0	Addition		Include Dental Benefits and other changes made to accommodate Dental Providers

