

APPENDIX B

MEDICARE PART "B" BENEFICIARY ELIGIBILITY INQUIRY

Medicare participating Part B physicians and suppliers and their designated billing service have automated access to beneficiary eligibility data as long as the provider bills electronically in the National Standard Format (NSF) or the ANSI X12 837 Transaction Set. Disclosure of Medicare Eligibility data is restricted under the provisions of the Privacy Act of 1974, 5 U.S.C. Section 552a. Under limited circumstances the Privacy Act permits us to disclose information without prior written consent of the individual to whom the information pertains; one of these is for "routine uses"; that is, disclosure for purposes that are compatible with the purpose for which we collect the information. In the case of Part B provider access, a routine use exists which permits release of data to providers and/or their billing agents for the purpose of preparing an accurate claim.

We offer beneficiary eligibility and deductible status information on a computer to computer telecommunication file transfer basis in either the HCFA Standard Part B Eligibility Inquiry Flat File Format, the American National Standards Institute (ANSI) Accredited Standards Committee X12 (ASC X12) 270 Health Care Eligibility/Benefit Inquiry and 271 Health Care Eligibility/Benefit Information Transaction Set (version 3051) and an on-line interactive screen access using Texas Health Information Network (THIN) Inquiry software.

Following are the instructions as published by HCFA:

- Access of eligibility data is only used for submitting an accurate claim;
- The provider must identify itself to access the data;
- Eligibility data may not be browsed; i.e., no data will be released except on a beneficiary specific basis. A provider may send up to 99 names at a time to be verified;
- Eligibility data is available only to participating physicians and suppliers that bill electronically using the National Standard Format (NSF) or the ANSI X12 Health Care Claim Transaction Set;
- Access will be available to the provider on a "toll" basis; that is, the provider will incur any long distance charges;
- Pertinent technical details are needed to access this data. The following minimum data is required to identify the beneficiary:
 - HICN
 - Surname
 - First initial and
 - Gender

To assure privacy and security while also providing a practical system to operate, the above criteria must match exactly to identify the beneficiary;

- Services must be rendered independent of the data in accordance with state and local laws regarding access to care;
- The eligibility data is only good for the time the provider is receiving it. This information could change at any time. Medicare Part B and HMO enrollment and termination dates are the most recent available. MSP shows that there has been past MSP activity. Providers should always develop for MSP, but it is especially important when the MSP indicator = D (e.g., past activity recorded);

- This data does not represent definitive eligibility status. If the individual is not in file, the provider must use the usual billing procedures in effect independent of this data access;
- It is important that providers use the patient ID field provided for them in both incoming and outgoing records. We will not edit this field, but will return it when it is present. It will be the only way a return, bearing corrected patient name or number, can be matched by the receiver; and
- Medicare eligibility information is confidential and the penalties available under the Privacy Act for illegal disclosure are being found guilty of a misdemeanor and fined not more than \$5,000.00.

In addition to the above, HCFA has defined the following security requirements:

- The claims to query ratio must not exceed 95 percent. Each quarter we will compile a report that balances claims against inquiries. To give providers a chance to become familiar with the system, the claims to inquiry ratio will start at 90 percent, and will go up for the next three months until it reaches 95 percent. This means that for every 100 inquiries received, there must be 90 claims submitted the first month, ending with 95 claims submitted for every 100 inquiries after the three month phase-in period. If the claims to inquiry ratio does not exceed 95 percent from a given participating physician or supplier, that physician or supplier will receive an educational contact from our office. If there is a problem or the behavior continues, then the provider loses inquiry access.

Submission of a NSF eligibility inquiry file requires an 80 byte E-Mail Logon prior to the header record in the following format:

EMAIL TYPE=ELI ID=NNNNNN PASSWORD=XXXXXX

Note: The ID and password are the EMC Submitter ID and corresponding password. These must be in the *THIN* security database.
The EMAIL header record is not necessary prior to the ANSI 270 transaction.

The eligibility response file will be prepared and loaded into the submitters mailbox for retrieval. The response file name will be in the following format based on the inquiry file format:

ELI00003.ELI.NSF_Cxxxxx (xxxxx = Carrier ID - 00900 for TX, 00901 for MD,
00902 for Delaware and 00903 for
the DC Metropolitan Area.)

or

ELI00006.ELI.ANSI_271

*Note: The “.ELI” extension will be replaced with “.ZIP” based on the users zip flag in the *THIN* database.

Following are the National Standard Format flat file specifications. The ANSI 270/271 Eligibility Implementation Guides may be downloaded from the HCFA EDI web site:

<http://www.hcfa.gov>

MEDICARE PART B - ELIGIBILITY REQUEST FORMAT

RECORD NAME: FILE HEADER RECORD

RECORD TYPE: ELI

<u>FIELD NO.</u>	<u>FIELD NAME</u>	<u>FIELD LENGTH</u>	<u>TYPE</u>	<u>POSITIONS FROM THRU</u>	
1	HEADER FIELD "ELI"	4	X	1	4
2	CARRIER NO.	5	N	5	9
3	PROVIDER ID	10	X	10	19
4	SUBMITTER ID	10	X	20	29
5	DATE & TIME STAMP	12	N	30	41
6	FILLER	4	X	42	45
7	FILLER - LOCAL	35	X	46	80

- CARRIER NO. - Must = 00900 for TX, 00901 for MD, 00902 for Delaware or 00903 for the DC Metropolitan Area.
- PROVIDER ID - Provider's Medicare number. Must be in the *THIN* security database.
- SUBMITTER ID - Must be in the *THIN* security database. Only the first 6 positions are used. (Left justify, right blank fill.)
- DATE & TIME STAMP - Must be: CCYYJJJHHMMS.
This is: Century, Year, Julian date, Hour, Minutes and Second. Enter the value of "0" for the last position - Second.

MEDICARE PART B - ELIGIBILITY REQUEST FORMAT

RECORD NAME: DETAIL REQUEST RECORD

RECORD TYPE: DETAIL

<u>FIELD NO.</u>	<u>FIELD NAME</u>	<u>FIELD LENGTH</u>	<u>TYPE</u>	<u>POSITIONS FROM THRU</u>	
1	RECORD TYPE "D"	1	X	1	1
2	PATIENT ID	17	X	2	18
3	PROVIDER ID	10	X	19	28
4	SUBMITTER ID	10	X	29	38
5	BENEFICIARY HICN	12	X	39	50
6	BENEFICIARY LAST NM	6	X	51	56
7	BENEFICIARY FIRST INT	1	X	57	57
8	GENDER ("M" OR "F")	1	X	58	58
9	FILLER - LOCAL	22	X	59	80

- PROVIDER ID - Must be in the *THIN* security database. (Left justify, right blank fill.)
- SUBMITTER ID - Must be in the *THIN* security database.
Only the first 6 positions are used. (Left justify, right blank fill.)
- If the eligibility of more than one beneficiary is requested in a single transmission, the second detail request will start immediately after the first detail request. One transmission may contain up to 99 detail requests.

MEDICARE PART B - ELIGIBILITY REQUEST FORMAT

RECORD NAME: FILE TRAILER RECORD

RECORD TYPE: TRAILER

<u>FIELD NO.</u>	<u>FIELD NAME</u>	<u>FIELD LENGTH</u>	<u>TYPE</u>	<u>POSITIONS FROM THRU</u>	
1	TOTAL DETAIL RECORDS	2	N	1	2
2	FILLER - LOCAL	78	X	3	80

MEDICARE PART B - ELIGIBILITY RESPONSE FORMAT

RECORD NAME: FILE HEADER RECORD

RECORD TYPE: RESP

<u>FIELD NO.</u>	<u>FIELD NAME</u>	<u>FIELD LENGTH</u>	<u>TYPE</u>	<u>POSITIONS FROM THRU</u>	
1	HEADER FIELD "RESP"	4	X	1	4
2	CARRIER NO.	5	N	5	9
3	DATE & TIME STAMP	12	N	10	21
4	FILLER	24	X	22	45
5	FILLER - LOCAL	85	X	46	130

- CARRIER NO. - Will equal 00900 for TX, 00901 for MD, 00902 for Delaware or 00903 for the DC Metropolitan Area.
- DATE & TIME STAMP - Format will be: CCYYJJJHHMMS. This is date and time stamp transmitted to us in the header record of the request file.

MEDICARE PART B - ELIGIBILITY RESPONSE FORMAT

RECORD NAME: DETAIL RESPONSE RECORD

RECORD TYPE: DETAIL

FIELD NO.	<u>FIELD NAME</u>	<u>FIELD LENGTH</u>	<u>TYPE</u>	<u>POSITIONS FROM THRU</u>	
1	RECORD TYPE "R"	1	X	1	1
2	PATIENT ID	17	X	2	18
3	PROVIDER ID	10	X	19	28
4	SUBMITTER ID	10	X	29	38
5	RESPONSE TYPE	2	N	39	40
6	BENEFICIARY HICN	12	X	41	52
7	BENEFICIARY LAST NM	6	X	53	58
8	BENEFICIARY FIRST INT	1	X	59	59
9	GENDER ("M" OR "F")	1	X	60	60
10	ENTITLEMENT DATE	6	D	61	66
11	TERMINATION DATE	6	D	67	72
12	CURRENT YR DEDUCT	2	N	73	74
13	CURRENT YR DED IND	1	X	75	75
14	PRIOR YR DEDUCT	2	N	76	77
15	PRIOR YR DED IND	1	X	78	78
16	HMO NAME	25	X	79	103
17	HMO ZIP CODE	5	N	104	108
18	HMO ENROLLMENT DATE	6	N	109	114
19	HMO TERM DATE	6	N	115	120
20	HMO CODE	1	X	121	121
21	MSP ACTIVITY	1	X	122	122
22	CHANGE CODE	1	X	123	123
23	FILLER	7	X	124	130

Refer to page 9 for definitions of these fields.

MEDICARE PART B - ELIGIBILITY RESPONSE FORMAT

RECORD NAME: TRAILER RESPONSE RECORD

RECORD TYPE: TRAILER

<u>FIELD NO.</u>	<u>FIELD NAME</u>	<u>FIELD LENGTH</u>	<u>TYPE</u>	<u>POSITIONS</u> <u>FROM THRU</u>	
1	TOTAL DETAIL RECORDS	2	N	1	2
2	FILE RESPONSE CODE	2	N	3	4
3	MESSAGE TEXT	100	X	5	104
4	FILLER - LOCAL	26	X	105	130

BENEFICIARY DETAIL RECORD DEFINITIONS:

<u>FLD</u> <u>NO.</u>	<u>FLD</u> <u>NAME</u>	<u>DEFINITION</u>
5	RESPONSE TYPE	11 - RESPONSE (THIS IS A DEFINITIVE REPLY) 21 - STILL SEARCHING - WILL RESPOND LATER 64 - INVALID OR MISSING HICN 65 - MISSING PATIENT NAME (SIRNAME OR FIRST INITIAL) 66 - MISSING OR INVALID GENDER 67 - NAME WITH HICN NOT FOUND 86 - PROVIDER/SUBMITTER NOT AUTHORIZED TO MAKE INQUIRY 90 - MORE THAN 99 INQUIRIES PROHIBITED
10	ENT DATE	BENE'S MEDICARE PART B ENTITLEMENT DATE (MMDDYY)
11	TERM DATE	BENE'S MEDICARE PART B TERMINATION DATE (MMDDYY)
12	CUR YR DED	YEAR FOR THE CURRENT DEDUCTIBLE (YY)
13	CUR YR DED IND	"Y" = DEDUCTIBLE MET "N" = DEDUCTIBLE NOT MET
14	PRIOR YR DED	YEAR FOR THE PRIOR DEDUCTIBLE (YY)
15	PR YR DED IND	"Y" = DEDUCTIBLE MET "N" = DEDUCTIBLE NOT MET
18	HMO DATE	MOST CURRENT HMO ENROLLMENT DATE (MMDDYY)
19	HMO DATE	MOST CURRENT HMO TERMINATION DATE (MMDDYY)
20	HMO CODE	"1" or "2" = COST HMO, "A", "B", or "C" = RISK HMO, SPACE = NON-HMO
21	MSP ACTIVITY	"D" = PROVIDER MUST DEVELOP FOR MSP ACTIVITY
22	CHANGE CODE	"Y" = BENE NAME OR NUMBER HAS BEEN CORRECTED AND THE CORRECT INFORMATION RETURNED. RECEIVER MUST USE THEIR PATIENT ID FOR MATCHING.