

Introduction

Your facility can save significant administrative time and expense by electronically performing routine functions, such as verifying patient eligibility and contacting the health insurer about the status of a claim. Access the educational resource “

Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule” to learn about the HIPAA electronic standard transactions, the HIPAA Transactions and Code Set rule and how this rule impacts your practice

Source: <https://www.stepsforward.org/Static/images/modules/20/-downloadable/need-to-know-everification.pdf>

Multiple search options

The eligibility request and response transactions provide the following options and patient information to assist you with obtaining and utilizing accurate patient information:

Required Alternate Search Options (all health plans support)

- Member ID, Date of Birth, Last Name
- Member ID, First Name, Last Name

Recommended Alternate Search Options (many health plans support)

- First Name, Last Name, Date of Birth
- Member ID, Date of Birth

Inquiry dates

- Single Date Type Request (Plan Date)

Expanded health plan details

- Plan begin date
- Plan end date, if established
- Plan name

Patient identifying information

- Correct demographic information needed by the health insurer for other transactions like the ASC X12 837 health care claim: professional and ASC X12 278 health care services review information (referral/authorization inquiry).

High level benefits

- Active coverage for any of the following: Medical Care, Chiropractic, Dental Care, Hospital, Emergency Services, Pharmacy, Physician Office Visit, Vision, Mental Health, Urgent Care

Other entities

- Primary Care Provider
- Other Payers

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) required that all health insurers support requirements of the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) 5010 Phase I & II Operating Rules by January 1, 2013. Many health plans already support the CAQH/CORE Phase I & II Operating Rule requirements. Visit http://www.caqh.org/CORE_organizations.php to see if the health insurers are on the list

Operating rule requirements include:

- The patient's portion of the financial responsibility must be returned (co-payment, co-insurance and patient-specific remaining deductible) for the following service type codes.

33 – Chiropractic
47 – Hospital
48 – Hospital Inpatient
50 – Hospital Outpatient
86 – Emergency Services
98 – Professional (Physician) Visit
UC – Urgent Care.

- The health insurer may, at its discretion, return copayment, coinsurance information and base deductible information for the following services specified in EB03-1365:

01 – Medical Care
30 – Health Plan Benefit Coverage
35 – Dental Care
88 – Pharmacy
AL – Vision (Optometry)
MH – Mental Health

- If the patient's portion of financial responsibility differs for in and out of network, both must be reported.

- Inquiries for dates 12 months in the past and to the end of the current month must be supported.

- Explicit requests must be supported for service type codes

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33 – Chiropractic
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