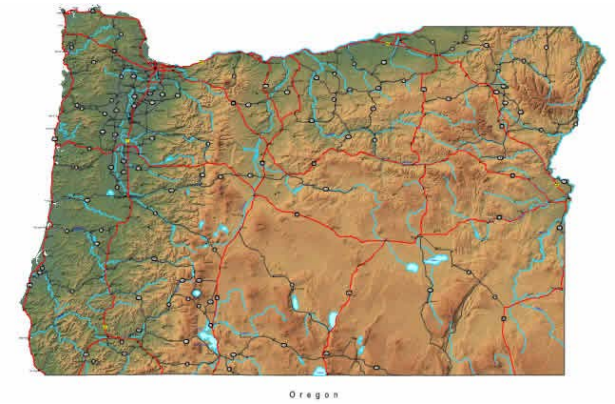

OREGON HEALTH AUTHORITY
OREGON HEALTH LEADERSHIP COUNCIL
ADMINISTRATIVE SIMPLIFICATION GROUP

Oregon Companion Guide

For the Implementation of the

ASC X12N/005010X279

HEALTH CARE ELIGIBILITY BENEFIT INQUIRY AND RESPONSE (270/271)

And the published errata:

- ***ASC X12N/005010X279E1 (JANUARY 2009)***
- ***ASC X12N/005010X279A1 (JUNE 2010)***

APRIL 2012
VERSION 2.0

Disclaimer
The following Oregon Companion Guide is intended to serve as a companion document to the corresponding *ASC X12N/005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271) and the errata documents subsequently published by ASC X12 (005010X279E1 and 005010X279A1).* Throughout the rest of the document, the ASC X12 technical report and attendant errata are referred to as 005010X279. The document further specifies the requirements to be used when preparing, submitting, receiving and processing electronic health care administrative data. The document supplements, but does not contradict, disagree, oppose, or otherwise modify the *005010X279* in a manner that will make its implementation by users to be out of compliance. Further, this guide is not a replacement for using the TR3: the TR3 is required for the compliant implementation of this transaction. Using this companion guide does not mean that a claim will be paid. It does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber.

Statutory Authority
It is intended that this companion guide will be adopted and its use will be mandated for all HIPAA covered entities (payers, providers, and clearinghouses) conducting business or licensed in the state of Oregon.

Document Changes
The content of this companion guide is subject to change. The version, release and effective date of the document are included in the document, as well as a description of the process for handling future updates or changes.

About the Oregon Department of Health
The Oregon Department of Health is responsible for protecting, maintaining and improving the health of Oregonians. The department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of Health Care Providers.
http://www.oregon.gov/DHS/

About the Oregon Health Authority
The Oregon Health Authority (OHA) was created by the 2009 Oregon legislature to bring most health-related programs in the state into a single agency to maximize its purchasing power. Although the state is in the planning stages for organizing the new agency, work to change the health care system has already begun. The OHA works with a nine-member, citizen-led board called the Oregon Health Policy Board. Members are appointed by the Governor and confirmed by the Senate. The Health Authority will transform the health care system in Oregon by; improving the lifelong health of Oregonians; Increasing the quality, reliability, and availability of care for all Oregonians; Lowering or containing the cost of care so it is affordable to everyone in the state.
http://www.oregon.gov/OHA/

About the Oregon Health Leadership Council
The Oregon Health Leadership Council is a collaborative organization working to develop practical solutions that reduce the rate of increase in health care costs and premiums so health care and insurance is more affordable to people and employers in the state. Formed in 2008 at the request of the Oregon business community, the council brings together health plans, hospitals and physicians to identify and act on cost-saving solutions that maximize efficiencies while delivering high quality patient care.
http://www.orhealthleadershipcouncil.org

About the Administrative Simplification Group
The Administrative Simplification group was first formed in the spring of 2008 by the Oregon Medical Association, Oregon Association of Hospitals & Health Systems and Regence BlueCross BlueShield of Oregon. After the formation of the Oregon Health Leadership Council, the workgroup became one of the four Leadership Council's workgroups.

This group identifies effective ways to simplify the administrative challenges faced by physicians and other healthcare professionals in order to streamline the business side of health care and provide cost-savings to the entire system. Three sub-groups were formed to explore increasing use of web sites for eligibility and claims information, investigate a common credentialing solution, and work toward standardization and automation of key processes.
http://www.orhealthleadershipcouncil.org/administrative-simplification

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Oregon Companion Guide Revision History

Ver.	Revision Date	Summary Changes
1.0	January 24th , 2011	Complete initial draft of Oregon Companion Guide (270/271)
1.1	October 24th , 2011	Changed contact phone number on page 2 (Disclaimer page)
2.0	April 30th, 2012	Updated to reflect phase 1 and 2 CORE operating rules

1 EXCERPT FROM STATEMENT: OREGON HEALTH AUTHORITY

The 2009 Oregon Legislative Assembly directed the Office for Oregon Health Policy and Research (OHPR) to bring together a work group to recommend uniform standards for insurers for, at a minimum, eligibility verification, claims processes, payment remittance advice, and claims payment. The Oregon Health Policy Board asked the work group to expand the legislative direction and include a broad strategy for administrative simplification, including specifying the appropriate role for the state, and to estimate the potential for cost savings that can be achieved through administrative simplification.

The goal of administrative simplification is to reduce total system costs and reduce the amount of provider resources that must be devoted to administrative transactions between providers of care and payers by simplifying and streamlining these activities.

(Please refer to Section 4, Appendix A : Statement from the Oregon Health Authority for a complete extract of this statement)

2 OVERVIEW

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) published rules (CMS–0009–F) announcing the adoption of new versions of the federal transaction standards, known as ASC X12/005010 ("Version 5010"). The compliance deadline to implement the 5010 version of the transaction standards, on a nationwide basis, is January 1, 2012.

One of the major transactions included in this version upgrade is the Health Care Eligibility Benefit Inquiry and Response (270/271). The standard was originally published on in April 2008 and two errata were published on January 2009 and June 2010.

The 'Eligibility' transaction is the transmission of either of the following:

(a) An inquiry from a Health Care Provider to a Health Plan, or from one Health Plan to another Health Plan, to obtain any of the following information about a benefit plan for an enrollee:

(1) Eligibility to receive health care under the Health Plan.
(2) Coverage of health care under the Health Plan.
(3) Benefits associated with the benefit plan.

(b) A response from a Health Plan to a Health Care Provider's (or another Health Plan's) inquiry described in paragraph (a).

Beginning January 1, 2012, Providers and Health Plans executing the Health Care Eligibility Benefit Inquiry and Response (270/271) transactions may only use the 5010 version of the Eligibility/Benefits Request/Response (005010X279).

2.1 Purpose of the Oregon Companion Guide

The purpose of the Oregon Companion Guide (OCG) is to clarify, supplement, and further define specific data content requirements to be used in conjunction with the 005010X279 (270/271) Technical Report Type 3 (TR3) created for the electronic transaction standard, mandated by the HIPAA regulations. Its purpose is to provide a common standard that can be easily and consistently applied by all Health Plans and Health Care Providers (refer definitions in Section 2.3) and yet, would continue to be fully compliant with federal regulations.

The term "Oregon Companion Guide" or its abbreviation "**OCG**" will be used consistently throughout this document to refer to the OCG being created at the request of the Oregon Health Authority.

2.2 Key Abbreviations

The following abbreviations are used extensively throughout this document

005010X279 Collective reference for the Health Care Eligibility Inquiry and Response transaction and published errata – inclusive of the following 3 documents:
ASC X12N/005010X279 (April 2008)
ASC X12N/005010X279E1 (January 2009)
ASC X12N/005010X279A1 (June 2010)

TR3 Technical Report Type 3 – formerly known as the Implementation Guide (IG)

OCG Oregon Companion Guide – this guide

2.2.1 005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271)

The reference for this OCG is the *005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271)* (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12 Format © 2008, Washington Publishing Company. All Rights Reserved). A copy of the full *005010X279* can be obtained from the Washington Publishing Company at http://www.wpc-edi.com.

2.3 Applicability

Effective October 1, 2012, all Health Plans licensed or doing business in Oregon and Health Care Providers providing services for a fee or as an encounter in Oregon, must exchange eligibility inquiry and response information electronically using

- 270/271 transaction as defined in the 5010 version
- the requirements of the OCG
- implement fully operational transactions within the timelines that will be required under proposed Oregon Statutes (see Section 3.3)

- The requirements do not apply to the exchange of electronic eligibility inquiry and response transactions with:
  - Medicare
  - Federally Administered programs
  - Workers' Compensation programs
  - Property and Casualty insurance plans

The following definitions apply to the HIPAA covered entities that will establish trading relationships using this OCG and are consistent with the definitions in the CFR 160 and 164.

2.3.1 Health Plan

Health Plan *is defined as follows:*

Note: *This definition reproduced from Subtitle D—Privacy, Section 13400. Definitions, that appear in the Conference Report on page H1345 of Congressional Record—House, February 12, 2009.*

An individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(2)).

(1) Health plan includes the following, singly or in combination:

- A group health plan
- A health insurance issuer
- An HMO
- Part A or Part B of the Medicare program under title XVIII of the Act.
- The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq.
- An issuer of a Medicare supplemental policy (as defined in section 1882(g) (1) of the Act, 42 U.S.C. 1395ss (g) (1)).
- An issuer of a long-term care policy, excluding a nursing home fixed- indemnity policy.
- An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
- The health care program for active military personnel under title 10 of the United States Code.
- The veterans' health care program under 38 U.S.C. chapter 17.
- The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)).
- The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.
- The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq.
- An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.
- The Medicare + Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.
- A high-risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.
- Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

- "Health Plan" includes an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974(ERISA)(29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care, as defined in section 2791(a)(2) of the Public Health Service (PHS) Act, 42U.S.C. 300gg–91(a)(2), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that (1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or (2) Is administered by an entity other than the employer that established and maintains the plan. *45 CFR 160 Subpart A 160.103*

(2) Health plan excludes:

- Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and
- A government-funded program (other than one listed in section 1 of this definition):
  (A) Whose principal purpose is other than providing, or paying the cost of, health care; OR
  (B) Whose principal activity is
    a. The direct provision of health care to persons; or
    b. The making of grants to fund the direct provision of health care to persons.

Health Plans may also be referred by the industry colloquial - **payers.**

2.3.2 HEALTH CARE PROVIDER

Health Care Provider *is defined as follows:*
A person or organization that provides health care or medical care services within Oregon for a fee and is eligible for reimbursement for these services. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a Health Plan, health carrier, or individual for providing health care services. This definition includes licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Health Care Providers may also be referred by the industry colloquial - **providers.**

2.3.3 CLEARINGHOUSE

Clearinghouse *is defined as follows:*
Entity contracted by Health Plans and Health Care Providers to create, send, receive, process, manage, or administrate standard electronic transactions are also subject to comply with the OCG. This would include entities that process the health care eligibility benefit inquiry and response (270/271) and other HIPAA standard X.12 transactions as or on behalf of a HIPAA covered entity.

2.3.4 TRADING PARTNER

The term Trading Partner is used in the most general sense of its meaning, in EDI terms, within this document. It essentially means any entity that exchanges EDI transactions with another entity, addressed by the scope of the OCG. The entity could be a direct submitter (such as a **Health Plan** or **Health Care Provider**) or an entity that provides EDI and billing agents (such as a **Clearinghouse**).

As described in the beginning of this section, this OCG applies to all eligibility inquiries and responses submitted electronically on or after October, 2012 (depending on actions of the Oregon legislature) that

use the transaction standard and corresponding *005010X279 (270/271).* The Code of Federal Regulations , title 45, part 162, subpart L specifies that the standard for dental, professional, and institutional health care eligibility benefit inquiry and response is this transaction standard.

2.4 Usage of Oregon Companion Guide – Consistency of Application

The 270/271 Health Care Eligibility Benefit transactions have the capacity for general as well as very specific requests (at the procedure code level) and very detailed responses. This document provides the agreed upon 'foundation' for a request/response. Through the minimum definition of search criteria (Section 3.2) the requirements are defaulted to those in the 5010 version of the transaction. This document does not prevent trading partners from agreeing to make more specific/detailed requests and receiving more detailed responses. However, the trading partners must all have at least the basic inquiry/response requirements provided in this document.

This OCG contains the maximum required set of data values to be submitted (search criteria) or received by Health Care Providers and Health Plans when executing an electronic eligibility inquiry (270) and response transaction (271). This OCG specifies how search criteria may be used in order to accomplish the goal of consistent, efficient, and error free execution of the transactions, among trading partners conducting business in the state of Oregon. The maximum requirements may be extended as per the conditions identified as follows:

1. No trading partner may unilaterally or collectively require any other trading partner(s) to conform to standards that are not included in this OCG.

2. Once adopted through Oregon State mandates, no additions or modifications may be made to this OCG by Health Plans or Health Care Providers through their own companion guides or by establishing other requirements.

3. All transactions must fully comply with the current version of the HIPAA 270/271 transaction TR3 (current version - 005010X279- published in April 2008 and updated through errata published in June 2010) in force at the time of executing the transactions.

4. Additional data elements and values may be included in the transaction based on the **mutual agreement** of trading partners. Agreement between one set of trading partners (as to use of additional information/detail) does not imply that the same agreement is required between other trading partners.

2.5 Updating the Oregon Companion Guide

This OCG will be reviewed and updated periodically to conform to prevailing rules and standards that change and evolve over time. The current set of rules and guidelines are described in the TR3 for the 270/271 transaction and two follow up errata that are incorporated in this version of the OCG.

2.5.1 FUTURE UPDATES TO OREGON COMPANION GUIDE--PROCESS

The 270/271 EDI Workgroup undertook responsibility to develop this OCG and it is intended that the group will continue to track industry changes and best practices in the implementation of this, and other Oregon Companion Guides (for the 837, 835, and 276/277 transactions).

In order to track these changes and incorporate relevant updates to the OCGs (including the 270/271 OCG), it is recommended that the workgroup retain its membership and organizational structure even after the first version of the OCGs is completed.

It is further recommended that the workgroup schedule to meet once every quarter to review industry news during the quarter, and make any recommendations to the Administration Simplification Executive Committee that may result in a change to the guide or operational aspects of executing transactions.

The Administration Simplification EDI Workgroup co-Chairs will retain the option of not calling the meeting if there are no newsworthy or pressing items that need discussion. Interest in scheduling a quarterly meeting may also be confirmed by polling the group sometime before the meeting.

When issues or changes come to light that must be addressed by the workgroup, the team can collectively make a recommendation to the Executive Committee with a new schedule and resource requests necessary to complete the work or resolve the issue(s) or incorporate valid changes to the OCG(s). The Executive Committee will then approve the recommendations on a case by case basis.

The specific process for updating OCG documents, including submitting and collecting change requests, reviewing and evaluating requests and making recommendations, adopting and publishing a new version of the guide will be available from the Oregon Health Authority's website at http://www.oregon.gov/OHA/.

2.6 Operating Rules and CORE

Operating rules can be generally defined as the content that must be returned in a response, and may include, but is not limited to, methods of communication, response times, and system availability times. Specifically they are defined in ACA (HR 3590) as follows.

(9) OPERATING RULES.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.

The task assigned to this workgroup was the development of an Oregon Companion Guide based off the federally required 005010X279, which has limited defined requirements for operating rules. Because of the interest in CORE (*Committee on Operating Rules for Information Exchange* of the Council for Affordable Quality Healthcare) especially by those participants certified in CORE---the workgroup did review a comparison of the CORE Phase 1, CORE Phase 2, and CORE Phase 3 service types along with the service types required (and supported) by the 5010 version of the 270/271 transaction set.

At the time Version 1.1 of this guide was developed, the CORE rules were associated with the 4010 version of the implementation guide and were being redeveloped for the 5010 version of this transaction. It was agreed that the workgroup would work with the eligibility and benefit content requirements laid out in the 5010 version of the TR3 and continue to monitor the development of additional content relevant to the 5010 TR3. The workgroup also agreed to monitor the industry direction for requiring operating rules as set forth in the Patient Protection Act (PPACA). The development of 'Best Practices' related to the 5010 version would be adopted when identified as important to the Oregon stakeholders.

In July, 2011, an Interim Final Rule was published by the Federal Government (Federal Register July 8, 2011 Rules and Regulations p. 40461 Administrative Simplification : Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions) proposing the adoption of Operating Rules developed by CAQH –CORE to be used in the clarification of and use of the 270/271 transaction. The following was published as part of the IFR in describing the place of the proposed operating rules as they related to the HIPAA transactions (including 270/271).

- They are business rules and guidelines;
- They are necessary for the electronic exchange of information;
- They are not defined by a standard;
- They do not conflict with the existing HIPAA standards;
- They are consensus based;
- They are consistent with the HIPAA and Health Information Technology (HIT) standards adopted by the Secretary; and
- Together with standards they
- ❖ Encourage the use of electronic transactions by reducing ambiguities currently permitted by the standard,
- ❖ Result in better-defined inquiries and responses that add value to provider practice management and health plan operations.

- The operating rules adopted, which affect this transaction, include (at a high level): Eligibility and Benefits Data Content
- Normalizing Patient Last Name
- Error Code Reporting
- System Availability
- Connectivity Protocols for Real Time as well as Batch transmissions rules

(See Table 1 for detail applicability of rules below)

Table 1 - CORE Phase I & II – Applicability to 270/271 OCG

Rule	Applicability*	Description
150	*Excluded*	Batch Acknowledgement Rule v.1.1.0 (*please note that though excluded as a named rule, this rule may be applicable via one of the adopted rules.*)
151	*Excluded*	Real Time Acknowledgement Rule v.1.1.0
152	*270/271*	Companion Guide Rule v.1.1.0
153	270/271	Connectivity Rule v.1.1.0
154	270/271	270/271 Data Content Rule v.1.1.0

Rule	Applicability*	Description
155	270/271	Batch Response Time Rule v.1.1.0
156	*270/271*	Real Time Response Time Rule v.1.1.0
157	270/271	System Availability Rule v.1.1.0
250	*Not Applicable*	Claim Status Rule
258	270/271	Normalizing Patient Last Name Rule
259	270/271	AAA Error Code Reporting Rule
260	270/271	Data Content Rule
270	270/271	Connectivity Rule

** Applicability to the 270/271 OCG*

The requirements for compliance with the new Federal Law does decrease the level of detail provided in this version of the OCG.

The date of compliance with the CORE Operating Rules as specified by the Federal Government is January 1, 2013, with certification by January 1, 2014. Certification requirements continue to be in development at the time of this writing.

2.7 Addressing Code Set Issues in the Oregon Companion Guide

Code sets utilized in HIPAA electronic transactions are classified as:

- Internal Transaction Codes (included and defined inside the *005010X279*).
- External Code Sets (referenced by *005010X279* defined and maintained by external bodies) including:
    1. Non-Medical External Code Sets (such as Taxonomy Codes, Claims Adjustment Reason Codes, Remark Codes, etc). These values may be effective based upon transaction date. These codes may also be effective based on the date of industry adoption or cease to be a validly used code if retired by industry agreement. The correct code set and code values will be used in the 270/271 transaction as applicable to the date of use.
    2. Medical and Dental External Code Sets (such as ICD-9, ICD-10, HCPCS; CDT). These values are effective based upon service date.

3 TRANSACTION REQUIREMENTS AND BEST PRACTICES

3.1 Oregon Requirements for Transaction Implementation

With the additional requirements of the recent federal legislation, some of the areas specified in previous versions of this guide are superseded by the federal requirements. The workgroup does reserve the right to add clarification, if during implementation, disagreements or concerns arise about the intent and use of the TR3.

A thorough review and understanding of various sections of the TR3 will allow for a successful implementation. These include:

a. the sections on business purpose and implementation
b. the TR3 notes applicable to specific loops and/or segments
c. the notes applicable to specific data elements
d. the usage of REQUIRED, SITUATIONAL and NOT USED for data elements, segments and loops

These are described in sections 3.1.1through 3.1.3 below.

3.1.1 TR3 Business Information

This section of the TR3 provides information regarding the purpose as well as implementation principles. Within these sections are details of requirements, which may not be obvious by reviewing only the technical sections of the report.

3.1.2 TR3 Notes

TR3 notes are designed to provide clear implementation detail regarding usage such as but not limited to:

- The number of times a loop or segment may or may not be repeated in a given situation.
- Dependencies when the loop or segment may be required based on data provided in another loop or segment.
- When data may be required based on the type of trading partner or intermediary.

3.1.3 Loops, Segments and Data Elements

This OCG does not reference the required and situational Loops, Segments and Data Elements contained in the 005010X279. The specific instructions associated with the transaction included in the TR3 are fully applicable to the covered entities without modification or qualification.

This Companion Guide does NOT include any of the Loops, Segments or Data Elements defined as NOT USED in the Reference *005010X279*. Consistent with the HIPAA requirements and

005010X279 instructions, the NOT USED Loops, Segments and Data Elements are not permitted to be submitted or received when conducting this transaction.

3.1.3.1 Required Loops, Segments and Data Elements

The Companion Guide adds no new or different values to those defined in the 005010X279.

3.1.3.2 Situational Loops, Segments and Data Elements

The Companion Guide accepts the conditions and values of Situational Loops, Segments and Data Elements to one of the following possibilities:

- Required, this means that in Oregon, group purchasers do consider and need this data for proper adjudication of the transaction and that the Loop, Segment and Data Element will be REQUIRED for ALL values further defined in the Oregon Companion Guide.

- Situational, with or without further definition of condition: this means that the Loop, Segment or Data Element will retain in the Oregon Companion Guide the original Situational classification given in the 005010X279, and that the Oregon Companion Guide will follow either:
  - ✓ The exact same conditions and values defined in the 005010X279 (because the conditions and values are close-ended, unambiguous, and straight-forward); or
  - ✓ A set of further refined conditions and values applicable to that Situational Loop, Segment or Data Element should the need arise as implementation progresses.

It is important to note that the parameters of Situational elements in the *00500X279* are generally written in a manner that creates a "requirement" for the element to be used (if such conditions are met).

3.2 Search Options Overview

In order to ensure consistency as well as the highest probability of a successful inquiry and accurate response, search options are discussed in this section. Three of the search options are required as part of the 270/271 TR3 and must be implemented. The Workgroup has also adopted a 4th required search option based on the needs of the provider community. The Workgroup has not been prescriptive in the requirements of 'how to search' for eligibility and benefits when a valid search option is used. We have provided in Section 3.2.1 ( ), examples of suggested search methodologies for each of the search options. We recognize that some application systems are already programmed to search with highly developed options. For those creating their own search methodologies, the appendix serves as a reference to the type of detail that will lead to a better result.

3.2.1 SEARCH OPTIONS

Information Sources must use the following Search Options (See Table 2) when responding to *005010X279* Health Care Eligibility Benefit Inquiry (270) transactions sent by Information Receivers. The goal of these search options is to increase the number of matches found by an Information Source. By maximizing the number of automated matches, both Information Receivers and Information Sources will experience fewer follow-up phone calls, which will reduce administrative costs. The Information Receiver should submit every available search option data element in each *005010X279* Health Care Eligibility Benefit Inquiry (270) transaction.

The options are designed so that an Information Source continues to look for the Subscriber/Dependent even if some of the data elements submitted do not match the Information Source's system. The options are not intended to require Information Receivers to continually resend the *005010X279* Health Care Eligibility Benefit Inquiry (270) transaction to fit the different options.

Table 2 - Search Options

Option	Subscriber Id	Last Name	First Name	Patient Dob
1	X	X	X	X
2	X	X		X
3	X	X	X	
4		X	X	X
5	X		X	X
6	X			X

Shaded rows are recommended for support but optional for this version of the OCG

These search options should be supported by all trading partners in the scope of this OCG.

- **Options 1, 2, 3, and 4 – required to be supported by this OCG**.
- **Options 5 and 6 – recommended they be supported by all trading partners.**

Notes:

1. *Trading partners unable to comply with search options 5 and 6 will not require a waiver from OHA, as these are recommended searches but not requirements.*
2. *In every case the use of the term '**positive response**', confirms the identification of a Subscriber that matches the inquiry criteria*
3. *In the previous version of this OCG, detail allowing consistent error responses when a member was not found in an electronic search was provided. This work was largely superseded by the federal regulation and has been removed from this guide.*

3.2.2 SEARCH - PRESCRIPTIVE EXAMPLE

This section includes one approach to filtering and matching transactions with Information Source records to ensure an accurate match

The key requirement is that an accurate and appropriate result be returned on the 271 in response to a 270 eligibility inquiry. Information Sources may use any filtering or search algorithm when matching the inquiry with their internal systems as long as the results returned on the response 271 transaction are accurate and appropriate.

The Search Options define a standard way to determine and report when an Information Source is unable to find the subscriber/dependent and, therefore, is unable to respond with eligibility information for the subscriber/dependent.

Refer to the *005010X279 and/or Operating Rules* for further information about rejecting a transaction for reasons other than subscriber/dependent not found.

3.2.2.1 Option #1: (Subscriber ID, Last Name, First Name, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits, Go to J.

B. Filter with DOB

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to C.
- Filter result with no hits, Go to H.

C. Filter with Last Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to D.
- Filter result with no hits, Go to F.

D. Filter with first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to E.
- Filter result with no hits

E. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
- Filter result with no hits.

F. Start over with B results and filter with first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to G.
- Filter result with no hits.

G. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits.
- Filter result with no hits.

H. Start over with A results and filter with Last Name and first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to I.
- Filter result with no hits, Go to J.

I. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
- Filter result with no hits

J. Start over and search with Last Name, first 3 letters First Name, and DOB.

- Search result with unique hit, positive response
- Search result with multiple hits, Go to K.
- Search result with no hits

K. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
- Filter result with no hits

3.2.2.2 Option #2: (Subscriber ID, Last Name, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits

B. Filter with DOB

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to C.
- Filter result with no

C. Filter with Last Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
- Filter result with no hits

3.2.2.3 Option #3: (Subscriber ID, Last Name, First Name)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits

B. Filter with Last Name

- Filter result with unique hit, Go to C.
- Filter result with multiple hits, Go to C.
- Filter result with no hits

C. Filter with first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to D.
- Filter result with no hits

D. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits ("Invalid/Missing DOB"– 58)
- Filter result with no hits

3.2.2.4 Option #4: (Last Name, First Name, DOB)

A. Search with Last Name, first 3 letters First Name, and DOB.

- Search result with unique hit, positive response
- Search result with multiple hits, Go to B.

- Search result with no hits

B. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
- Filter result with no hits

3.2.2.5 Option #5: (Subscriber ID, First Name, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits

B. Filter with DOB

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to C.
- Filter result with no hits

C. Filter with first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to D.
- Filter result with no hits

D. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
- Filter result with no hits

3.2.2.6 Option #6: (Subscriber ID, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits

B. Filter with DOB

- Filter result with unique hit, positive response
- Filter result with multiple hits
- Filter result with no hits

3.3 Implementation Schedule

The current schedule for the release of this OCG for the 270/271 transaction, based on the Oregon Health Authority direction, is as follows:

January 1, 2012	All trading partners using 270/271 transactions conform to OCG v1.1
October 1, 2012	**All Oregon entities must conduct such** (eligibility inquiry and response) **transactions electronically conforming to the OCG**
January 1, 2013	**All trading partners using 270/271 transactions conform to OCG v2.0**

(This date is consistent with the adoption date for CORE phase 1 & 2 rules)

3.4 The Development of 'Best Practices'

The Oregon Administrative Simplification Work Group is continuously working on the identification of 'Best Practices' for the implementation of administrative transactions and processes. 'Best Practices' are consensus recommendations of the EDI Workgroup to further standardize and harmonize health care administrative transactions for the entities to whom the OCG applies. Best Practices, when developed, will not be a part of the OCG---but will be posted at the Oregon Administrative Simplification website and updated, as the industry needs change. When this version of the guide was developed, best practices that had been included, were superseded by federal law—and were removed from the OCG.

4 APPENDIX A : STATEMENT FROM THE OREGON HEALTH AUTHORITY

The 2009 Oregon Legislative Assembly directed the Office for Oregon Health Policy and Research (OHPR) to bring together a work group to recommend uniform standards for insurers for, at a minimum, eligibility verification, claims processes, payment remittance advice, and claims payment. The Oregon Health Policy Board asked the work group to expand the legislative direction and include a broad strategy for administrative simplification, including specifying the appropriate role for the state, and to estimate the potential for cost savings that can be achieved through administrative simplification.

The goal of administrative simplification is to reduce total system costs and reduce the amount of provider resources that must be devoted to administrative transactions between providers of care and payers by simplifying and streamlining these activities.

The keys to simplification are elimination, standardization, and automation of processes. In Oregon, many transactions that would be automated in other industries are still performed manually by most providers and many payers. The healthcare industry is unlikely to take major strides toward automated processes until there is greater standardization of the methods for conducting the transactions electronically. Standardization has proven difficult for the industry to achieve on a voluntary basis. Standardization requires each individual business to make upfront investment in changing systems and work processes. Such investments are rational only if all, or nearly all, providers and payers with which they deal are making similar investments at the same time. Therefore, the state has a central role in enabling the industry to move forward together to greater simplification and automation of administrative processes.

The work group made several recommendations and estimated that failure to take these steps outlined in this report would cost Oregon payers and providers nearly $100 million in administrative savings each year. The work group makes the following recommendations:

Recommendation #1: Oregon should adopt the Minnesota approach to standardization and automation.

Recommendation #2: Oregon requirements for standardization and automation should be phased-in. This means that providers and payers should be given time to adjust to the changes.

Recommendation #3: Oregon should lead. Oregon should not wait for the federal government to standardize HIPAA transactions.

Recommendation #4: Technical assistance to providers will be important to help providers adjust to and take full advantage of administrative simplification opportunities.

Recommendation #5: There is need for on-going public-private partnerships to identify successes, challenges, and opportunities for future administrative simplification.

To carry out these recommendations, the following steps will need to be taken:

- The Department of Consumer & Business Services must adopt by rule uniform companion guides for eligibility verification, claims, and payment remittance advice by adapting the Minnesota uniform companion guides. The rules should require insurers and the providers that do business with them to conduct the transactions electronically about a year after adoption of each uniform companion guide.

- The Legislature must enact legislation in 2011 giving DCBS authority to establish uniform standards for healthcare administrative transactions to all payers (including third party administrators and self-insured plans) and clearinghouses and to collect data from them to monitor progress and identify future opportunities.

- The Oregon Health Authority as a payer should follow the DCBS rules and require Medicaid managed care organizations, Medicaid providers, and others with which it deals to do so as well.

- DCBS must require insurers and other payers to perform additional transactions electronically on a phased-in basis between 2014 and 2016—setting the dates for each transaction to go "all-electronic" no later than one year after a HIPAA standard and uniform companion guide or uniform operating rules have been adopted by the U.S. Department of Human Services.

- The industry should bring forward its recommendation to develop a single sign-on to health plan web portals and a single source for information used in physician credentialing. In addition, the industry should identify and develop additional opportunities for standardization.

- The Insurance Commissioner and the Director of the Oregon Health Authority should take joint responsibility for continued progress toward greater administrative simplification. They should carry out these responsibilities in collaboration with providers and payers, collecting data to evaluate progress; establishing priorities, goals, benchmarks, and timelines; and using rulemaking authority as necessary.

5 APPENDIX B : REFERENCES AND BIBLIOGRAPHY

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