



South Carolina

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**ASC X12N 270 (004010X092A1)
HEALTH CARE ELIGIBILITY BENEFIT INQUIRY
SUPPLEMENTAL IMPLEMENTATION GUIDE**

Revised September 10, 2008

270 ELIGIBILITY, COVERAGE OR BENEFIT INQUIRY

Functional Group ID=**HS**

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INTRODUCTION

The Secretary of Health and Human Services has established version 4010A1 of the X12N 270 Eligibility/Benefit Request Transactions implementation guides as national standards for use by all health plans in the United States. This fulfills certain requirements of the Administrative Simplification provisions of HIPAA. Further information on the HIPAA standards requirements in general may be obtained at <http://aspe.hhs.gov/admsimp>.

This Supplemental Implementation Guide (SIG) contains the requirements for implementation of the eligibility request by the standard system maintainers and intermediaries. This Draft Standard for Trial Use contains the format and establishes the data contents of the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to inquire about the eligibility, coverage or benefits associated with a benefit plan, employer, plan sponsor, subscriber or a dependent under the subscriber's policy. The transaction set is intended to be used by all lines of insurance such as Health, Life, and Property and Casualty.

Version 4010A1 (addenda) of the 270 transaction will be the version recognized by BlueCross BlueShield of South Carolina.

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 270/271 implementation guide. The use of this document is solely for the purpose of clarification. The information describes specific requirements to be used in processing BlueCross BlueShield of South Carolina and its subsidiaries' HIPAA ANSI X12N 270 Eligibility/Benefit Request transaction. Please note that the HIPAA ANSI X12N 270 Supplemental Implementation Guide is subject to change. Any changes will be available at www.SouthCarolinaBlues.com.

BlueCross BlueShield of South Carolina currently accepts one type of transaction per transmission. Therefore, all ST01 elements within the transmission will equal the same transaction number. For example, fourteen 837I transactions are acceptable within one enveloping sequence, but thirteen 837Is and one 276 within one enveloping sequence is unacceptable.

REVISION LOG

Date	Author	Revision Description
April 2, 2003		Original with 4010A1
October 29, 2003	E. Baylor-Elks	Formatting
November 12, 2003	E. Baylor-Elks	Added ST01 note to introduction
December 2, 2003	E. Baylor-Elks	Made corrections to notes, etc.
December 16, 2004	E. Baylor-Elks	Added missing shading to segments; removed 2100C/2110C/2100D/2110D DTP segments, segments used per IG.
May 20, 2005	E. Baylor-Elks	Added BlueChoice HealthPlan, removed Companion HealthCare.
September 10, 2008	E. Baylor-Elks	NPI modifications

270 (Eligibility) Processing Guidelines for BlueCross BlueShield of South Carolina and its affiliates when acting as the Information Source

In addition to these Guidelines, this document provides information detailing what BlueCross BlueShield of South Carolina and its affiliated companies expect in a particular loop/segment/element. All other loops/segments/elements shall be used according to HIPPA 270 Implementation Guide specifications regarding codes, repeats, usage, etc.

Summary of required data elements for coverage request:	
Appropriate tax ID in Information Source NM109	Required
Subscriber ID	Required
Subscriber date of birth or first and last name	Required
If requesting for dependent, dependent date of birth or first and last name	Conditional
Appropriate coverage service type (30,35,88,AL)	Required

Summary of required data elements for benefit request:	
Elements indicated for coverage request other than coverage service type	Required
Place of service	Required
Service type or procedure code	Required
Performing provider ID or performing provider specialty	May be derived
Billing provider ID or provider type (institutional/professional)	May be derived
Diagnosis code	May be derived

“Information Receiver” refers to the entity requesting benefit information.

“Information Source” refers to BlueCross BlueShield of South Carolina and its affiliated companies.

To receive detailed benefit information, one of four sets of conditions must be met.

1. **Detailed benefits must be requested.** Detailed benefits can be requested by service type (a valid value in EQ01) or by procedure code (a valid value in EQ02-2).

For **Professional inquiries** (defined below) requests by service type and procedure code are supported. However, some service types are so broadly defined that no one set of detailed benefits can answer the question. For these broad service types, detailed benefits will not be returned. Also, for procedure code inquiries, only dental (C00301 = AD), CPT4 (EQ02-1=CJ) and HCPCS (EQ02-1=HC) are supported.

For **Institutional inquiries** (defined below), only service type is supported. However, some service types are so broadly defined that no one set of detailed benefits can answer the question. For these broad service types, detailed benefits will not be returned.

If the billing provider is identified as an INSTITUTIONAL provider on the Information Source's provider files or as determined from the taxonomy code, then the query is considered an Institutional query. If the billing provider is identified as a PROFESSIONAL provider on the Information Source's provider files or as determined from the taxonomy code, then the query is considered a Professional query.

2. Some information about the performing provider must be available (although it might be derived). The Information Receiver should *always* provide performing provider information if it is available. The performing provider is identified using the PRV01 value of PE. The PRV01 value can be given in:
 1. The PRV segment for the Information Receiver (Loop 2100B), or
 2. The loop that identifies the patient (either Loop 2100C if the subscriber is the patient, or Loop 2100D if the dependent is the patient).

If the identification code is given, it must be for a Federal Taxpayer's Identification Number, a Social Security Number, or the Service Provider Number. The performing provider's identification code may be given in two places:

1. The Information Receiver loop 2100B at data element NM109, with the NM108 qualifier indicating whether the code is:
 - a) A Federal Taxpayer's Identification Number ('FI'),
 - b) A Social Security Number ('34'), or
 - c) A Service Provider Number ('SV');
2. The loop that identifies the patient (either Loop 2100C if the subscriber is the patient, or Loop 2100D if the dependent is the patient) at data element PRV03, with the PRV02 qualifier indicating whether the code is:
 - a) A Federal Taxpayer's Identification Number ('TJ'),
 - b) A Social Security Number ('SY'), or
 - c) A Service Provider Number ('9K'). *

**The code values differ between segments due to separate code collections being used for each segment.*

In order for the performing provider identification code to be used in determining detailed benefits, the code must be loaded to the Information Source's provider files, and must be accurately identified as to Federal Taxpayer's Identification Number, Social Security Number, or Service Provider Number. In order to receive PCP level benefits in managed care, the performing provider must also be identified as the patient's PCP in the Information Source's files.

If the performing provider's identification code is not provided, or is provided but is not found on the Information Source's provider files, then the performing provider taxonomy code will be used in determining detailed benefits. For both the Information Receiver (Loop 2100B) and the patient (either 2100C or 2100B) the taxonomy code is given in data element PRV03, identified by a code of 'ZZ' in PRV02.

In some cases detailed benefits can be given when the performing provider information (identification code or taxonomy code) is not given in the query, or the performing provider data has not been loaded to the provider files, or even when a performing provider is not identified at all. In these cases the performing provider information might be derived. See D. below for more information.

- 3.** Information about the billing provider is useful, and the Information Receiver should provide billing provider information if it is available. *Billing provider information will only be used if valid rendering provider information is also given.* The billing provider is identified using the PRV01 value of BI. The PRV01 value can be given in the PRV segment for the Information Receiver (Loop 2100B), or in the loop that identifies the patient (either Loop 2100C if the subscriber is the patient, or Loop 2100D if the dependent is the patient).

The billing provider's identification code must be a Federal Taxpayer's Identification Number, a Social Security Number, or the Service Provider Number. The identification code may be given in:

1. The Information Receiver loop 2100B at data element NM109, with the NM108 qualifier indicating whether the code is a:
 - a) Federal Taxpayer's Identification Number ('FI'),
 - b) Social Security Number ('34'), or
 - c) Service Provider Number ('SV').
2. The loop that identifies the patient (either Loop 2100C if the subscriber is the patient, or Loop 2100D if the dependent is the patient) at data element PRV03 with the PRV02 qualifier indicating whether the code is a:
 - a) Federal Taxpayer's Identification Number ('TJ'),
 - b) Social Security Number ('SY'), or
 - c) Service Provider Number ('9K').

In order for the billing provider identification code to be used in determining detailed benefits, the code must be loaded to the Information Source's provider files, and must be accurately identified as to Federal Taxpayer's Identification Number, Social Security Number, or Service Provider Number. Also, the *performing* provider's identification code must have been located on the Information Source's provider files.

If the billing provider's identification code is not provided, but the performing provider's identification code was both provided and was located on the provider files, then the billing provider's identification code will be derived from the performing provider's identification code.

If the billing provider's identification code is not provided, is not derived, or is not found on the Information Source's provider files, then the billing provider taxonomy code will be used in determining detailed benefits. For both the Information Receiver (Loop 2100B) and the patient (either 2100C or 2100B) the taxonomy code is given in data element PRV03, identified by a code of 'ZZ' in PRV02. Also, the *performing* provider's identification code must have been located on the Information Source's provider files, or a *performing* provider's taxonomy code must have been provided before the billing provider taxonomy is used.

4. When the performing provider's identification code is not given (in NM109 or PRV03), or is not of a valid type (NM108 or PRV02 does not specify Federal Taxpayer's Identification Number, Social Security Number, or Service Provider Number), or is not located on the Information Source's provider files, *and* no valid performing provider taxonomy code is given, then the Information Source will still attempt to provide detailed benefits. The performing provider information will be derived, wherever possible, from the service type or procedure code used.

In all cases the benefits given will be for a performing provider whose specialty is able to perform the service or procedure.

If the query uses a procedure code, then the benefits will be for a professional provider.

If the query uses a service type then the service type must be for a sufficiently narrow range of procedures, so that only a single set of benefits can cover the service type. In addition, the service type must be for either a professional service or an institutional service, but not for one that can be performed by both.

If detailed benefits cannot be determined, then a generic response for eligibility/coverage will be returned. This *does not necessarily* mean the specific service is covered. Data element EB03 in the 271 response will be valued with '30' for medical, '35' for dental, '88' for drug, and 'AL' for vision.

Segment: **NM1** Information Source Name
Position: 030
Loop: 2100A
Level: Detail
Usage: Mandatory
Max Use: 1

Data Element Summary

Ref.	Data	Name
Des.	Element	Code
NM108	66	Identification Code Qualifier
		This required value must equal "FI" to indicate a Federal Taxpayer's Identification Number in element 09.
		FI Federal Taxpayer's Identification Number
NM109	67	Identification Code
		The following codes are accepted.
		201393447 Instil Health Insurance Company
		570287419 BlueCross BlueShield of South Carolina
		570523959 Companion Life Ins Co
		570768835 BlueChoice HealthPlan
		592876465 Florida Combined Life

Segment: NM1 Information Receiver Name
Position: 030
Loop: 2100B
Level: Detail
Usage: Mandatory
Max Use: 1

Data Element Summary

Ref.	Data	Name
Des.	Element	Entity Type Qualifier
NM102	1065	<p>Entity Type Qualifier</p> <p>If the entity requesting benefits information is an individual, this element should be '1'. If the entity requesting benefits is an organization, this element should be '2'.</p> <p>1 Person 2 Non-Person Entity</p>
NM103	1035	<p>Name Last or Organization Name</p> <p>Report the individual's last name if element 03 indicates a person, or the organization name if element 03 indicates an organization.</p>
NM104	1036	<p>Name First</p> <p>Report the requestor's first name in this element if the requestor is an individual.</p>
NM105	1037	<p>Name Middle</p> <p>Report the requestor's middle name in this element if the requestor is an individual.</p>
NM107	1039	<p>Name Suffix</p> <p>Report the requestor's name suffix in this element if the requestor is an individual.</p>
NM108	66	<p>Identification Code Qualifier</p> <p>All providers eligible under CMS guidelines to receive a National Provider ID number must report the NPI number in element 09, using the qualifier 'XX' in element 08.</p> <p>If a provider is not eligible to receive a NPI, element 09 may contain either the provider's:</p> <ul style="list-style-type: none"> • Employer Identification Number, • Social Security Number, or • Payer-assigned Provider Number. <p>34 Social Security Number FI Federal Taxpayer's Identification Number SV Service Provider Number XX Health Care Financing Administration National Provider Identifier</p>

Segment: **PRV** Information Receiver Provider Information
Position: 090
Loop: 2100B
Level: Detail
Usage: Optional
Max Use: 1
Notes: If submitting both billing and performing provider, the information receiver must be one or the other. The PRV segment must be included to identify which provider is the Information Receiver. The other provider number must be reported in the PRV segment at Patient level, either subscriber or dependent. Please see the processing guidelines for further explanation.

Data Element Summary

Ref.	Data Element	Name
PRV01	1221	Provider Code If the value in this element is anything other than 'BI' or 'PE', the information in this loop will be ignored. BI Billing PE Performing
PRV02	128	Reference Identification Qualifier All providers eligible under CMS guidelines to receive a National Provider ID number must report the NPI number in element 03, using the qualifier 'HPI' in element 02. If a provider is not eligible to receive a NPI, either the Employer Identification Number or the provider's Social Security Number may be used in element 03, and element 02 may contain either 'SY' or 'TJ'. EI Employer's Identification Number SY Social Security Number

Segment: **NM1** Subscriber Name
Position: 030
Loop: 2100C
Level: Detail
Usage: Mandatory
Max Use: 1
Notes: In addition to the subscriber's Member ID Number (NM109), subscriber matching requires that either the subscriber's last and first name (NM103 and NM104) is reported, or the subscriber's date of birth is reported in the 2100C-DMG loop.

Data Element Summary

Ref.	Data Element	Name
NM108	66	Identification Code Qualifier This required element must be 'MI' to indicate that the number reported in element 09 is the Member Identification Number from the subscriber's insurance card. MI Member Identification Number

Segment: **PRV** **Provider Information**
Position: 090
Loop: 2100C
Level: Detail
Usage: Optional
Max Use: 1
Notes: If submitting both billing and performing provider, the information receiver must be one or the other. The PRV segment must be included to identify which provider is the Information Receiver. The other provider number must be reported in the PRV segment at Patient level, either subscriber or dependent. Please see the processing guidelines for further explanation.

Data Element Summary

Ref.	Data Element	Name
PRV01	1221	Provider Code The following codes are accepted. BI Billing PE Performing
PRV02	128	Reference Identification Qualifier All providers eligible under CMS guidelines to receive a National Provider ID number must report the NPI number in element 03, using the qualifier 'HPI' in element 02. If a provider is not eligible to receive a NPI, either the Employer Identification Number or the provider's Social Security Number may be used in element 03, and element 02 may contain either 'SY' or 'TJ'. HPI Health Care Financing Administration National Provider Identifier SY Social Security Number TJ Federal Taxpayer's Identification Number

Segment: **DMG** **Subscriber Demographic Information**
Position: 100
Loop: 2100C
Level: Detail
Usage: Optional
Max Use: 1
Notes: If the subscriber's first and last names are not reported in the NM1 segment, the subscriber's date of birth (DMG02) is required in this segment for subscriber matching.

Segment: EQ **Subscriber Eligibility or Benefit Inquiry Information**
Position: 130
Loop: 2110C
Level: Detail
Usage: Optional
Max Use: 1
Notes: See Processing Guidelines for further explanation on the use of this loop.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>
<u>Des.</u>	<u>Element</u>	<u>Service Type Code</u>
EQ01	1365	Service types "88" and "AL" will be considered as requests for coverage information only. Detailed benefits for these services will not be returned in the response..
1	Medical Care	74 Private Duty Nursing
2	Surgical	75 Prosthetic Device
3	Consultation	76 Dialysis
4	Diagnostic X-Ray	77 Otological Exam
5	Diagnostic Lab	78 Chemotherapy
6	Radiation Therapy	79 Allergy Testing
7	Anesthesia	80 Immunizations
8	Surgical Assistance	81 Routine Physical
9	Other Medical	82 Family Planning
10	Blood Charges	83 Infertility
11	Used Durable Medical Equipment	84 Abortion
12	Durable Medical Equipment Purchase	85 AIDS
13	Ambulatory Service Center Facility	86 Emergency Services
14	Renal Supplies in the Home	87 Cancer
15	Alternate Method Dialysis	88 Pharmacy
16	Chronic Renal Disease (CRD) Equipment	89 Free Standing Prescription Drug
17	Pre-Admission Testing	90 Mail-Order Prescription Drug
18	Durable Medical Equipment Rental	91 Brand-Name Prescription Drug
19	Pneumonia Vaccine	92 Generic Prescription Drug
20	Second Surgical Opinion	93 Podiatry
21	Third Surgical Opinion	94 Podiatry - Office Visits
22	Social Work	95 Podiatry - Nursing Home Visits
23	Diagnostic Dental	96 Professional (Physician)
24	Periodontics	97 Anesthesiologist
25	Restorative	98 Professional (Physician) Visit - Office
26	Endodontics	99 Professional (Physician) Visit - Inpatient
27	Maxillofacial Prosthetics	A0 Professional (Physician) Visit - Outpatient
28	Adjunctive Dental Services	A1 Professional (Physician) Visit - Nursing Home
30	Health Benefit Plan Coverage	A2 Professional (Physician) Visit - Skilled Nursing Facility
32	Plan Waiting Period	A3 Professional (Physician) Visit - Home
33	Chiropractic	A4 Psychiatric
34	Chiropractic Office Visits	A5 Psychiatric - Room and Board
35	Dental Care	A6 Psychotherapy
36	Dental Crowns	A7 Psychiatric - Inpatient
37	Dental Accident	A8 Psychiatric - Outpatient
38	Orthodontics	A9 Rehabilitation
39	Prosthodontics	AA Rehabilitation - Room and Board

Continued on next page

40	Oral Surgery	AB	Rehabilitation - Inpatient
41	Routine (Preventive) Dental	AC	Rehabilitation - Outpatient
42	Home Health Care	AD	Occupational Therapy
43	Home Health Prescriptions	AE	Physical Medicine
44	Home Health Visits	AF	Speech Therapy
45	Hospice	AG	Skilled Nursing Care
46	Respite Care	AH	Skilled Nursing Care - Room and Board
47	Hospital	AI	Substance Abuse
48	Hospital - Inpatient	AJ	Alcoholism
49	Hospital - Room and Board	AK	Drug Addiction
50	Hospital - Outpatient	AL	Vision (Optometry)
51	Hospital - Emergency Accident	AM	Frames
52	Hospital - Emergency Medical	AN	Routine Exam
53	Hospital - Ambulatory Surgical	AO	Lenses
54	Long Term Care	AQ	Nonmedically Necessary Physical
55	Major Medical	AR	Experimental Drug Therapy
56	Medically Related Transportation	BA	Independent Medical Evaluation
57	Air Transportation	BB	Partial Hospitalization (Psychiatric)
58	Cabulance	BC	Day Care (Psychiatric)
59	Licensed Ambulance	BD	Cognitive Therapy
60	General Benefits	BE	Massage Therapy
61	In-vitro Fertilization	BF	Pulmonary Rehabilitation
62	MRI/CAT Scan	BG	Cardiac Rehabilitation
63	Donor Procedures	BH	Pediatric
64	Acupuncture	BI	Nursery
65	Newborn Care	BJ	Skin
66	Pathology	BK	Orthopedic
67	Smoking Cessation	BL	Cardiac
68	Well Baby Care	BM	Lymphatic
69	Maternity	BN	Gastrointestinal
70	Transplants	BP	Endocrine
71	Audiology Exam	BQ	Neurology
72	Inhalation Therapy	BR	Eye
73	Diagnostic Medical	BS	Invasive Procedures

EQ02 C003 Composite Medical Procedure Identifier

BlueCross BlueShield of South Carolina uses procedure codes to determine benefits when the rendering provider is identified as a Professional provider within the system's provider files. Institutional providers receive benefits based solely upon service type.

C00301 235 Product/Service ID Qualifier

HCPCS (HC), American Dental Association (AD) or CPT4 (CJ) codes are accepted.

AD	American Dental Association Codes
CJ	Current Procedural Terminology (CPT) Codes
HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

Segment: **III** **Subscriber Eligibility or Benefit Additional Inquiry Information**
Position: 170
Loop: 2110C
Level: Detail
Usage: Optional
Max Use: 10
Notes: Two repeats of the III--Subscriber Eligibility or Benefit Inquiry Information are required. One repeat must contain the ICD-9 Principle Diagnosis Code, and the other must contain the Facility Type Code.

1) Diagnosis Code: Information Source will use only one diagnosis code to determine benefits. When two or more diagnosis codes are reported using both the Principle Diagnosis ('BK') and Diagnosis ('BF') qualifiers, the principle diagnosis code qualified by 'BK' will be used when determining benefits.

2) Facility Type Code: Place of service is required in order to determine benefits. If a place of service is not reported, BlueCross BlueShield of South Carolina will default the place of service based upon information in the system's provider files, and return benefits based upon the default.

If a place of service is implied in a service type (EQ01) and a conflicting place of service code is reported in this segment, the implied place of service will be used to determine benefits. For example, when service type 48 (hospital--inpatient) is reported as the service type in EQ01, and the facility type code in this segment is reported as 12 (home), the benefits will be based upon inpatient hospital--the service type's implied place of service.

Data Element Summary

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
III01	1270	Code List Qualifier Code	
		BF	Diagnosis
		BK	Principal Diagnosis
		ZZ	Mutually Defined
III02	1271	Industry Code	
		<i>Facility Type Code</i>	
1	Pharmacy	32	Nursing Facility
2	Unassigned	33	Custodial Care Facility
3	School	34	Hospice
4	Homeless Shelter	41	Ambulance--Land
5	Indian Health Service Free-standing Facility	42	Ambulance--Air or Water
6	Indian Health Service Provider-based Facility	49	Independent Clinic
7	Tribal 638 Free-standing Facility	50	Federally Qualified Health Center
8	Tribal 638 Provider-based Facility	51	Inpatient Psychiatric Facility
9	Prison-Correctional Facility	52	Psychiatric Facility--Partial Hospitalization
11	Office	53	Community Mental Health Center
12	Home	54	Intermediate Care Facility/Mentally Retarded
13	Assisted Living Facility	55	Residential Substance Abuse Treatment Facility
14	Group Home	56	Psychiatric Residential Treatment Center
15	Mobile Unit	57	Non-residential Substance Abuse Treatment Facility
20	Urgent Care Facility	60	Mass Immunization Center
21	Inpatient Hospital	61	Comprehensive Inpatient Rehabilitation Facility
22	Outpatient Hospital	62	Comprehensive Outpatient Rehabilitation Facility

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23	Emergency Room--Hospital	65	End-Stage Renal Disease Treatment Facility
24	Ambulatory Surgical Center	71	Public Health Clinic
25	Birth Center	72	Rural Health Clinic
26	Military Treatment Facility	81	Independent Laboratory
31	Skilled Nursing Facility	99	Other Place of Service

Segment: **NM1** Dependent Name

Position: 030

Loop: 2100D

Level: Detail

Usage: Mandatory

Max Use: 1

Notes: Subscriber matching requires population of either the dependent's full name (NM103 and NM104) or the dependent's date of birth in the DMG loop.

Data Element Summary

Ref.	Data	Name
Des.	Element	Identification Code Qualifier
NM108	66	

This required element must be 'MI' to indicate that the number reported in element 09 is the Member Identification Number from the subscriber's insurance card.

MI	Member Identification Number
----	------------------------------

Segment: **PRV** **Provider Information**

Position: 090

Loop: 2100D

Level: Detail

Usage: Optional

Max Use: 1

Notes: If submitting both billing and performing providers, this provider must be one or the other. The provider in the Information Receiver loop must be identified as the other provider via the PRV segment in that loop. See the processing guidelines for further explanation on the use of this loop.

Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>						
PRV01	1221	Provider Code The following codes are accepted. Any other value will result in this loop being ignored. <table border="0"> <tr> <td>BI</td> <td>Billing</td> </tr> <tr> <td>PE</td> <td>Performing</td> </tr> </table>	BI	Billing	PE	Performing		
BI	Billing							
PE	Performing							
PRV02	128	Reference Identification Qualifier All providers eligible under CMS guidelines to receive a National Provider ID number must report the NPI number in element 03, using the qualifier 'HPI' in element 02. If a provider is not eligible to receive a NPI, either the Employer Identification Number or the provider's Social Security Number may be used in element 03, and element 02 may contain either 'SY' or 'TJ'. <table border="0"> <tr> <td>HPI</td> <td>Health Care Financing Administration National Provider Identifier</td> </tr> <tr> <td>SY</td> <td>Social Security Number</td> </tr> <tr> <td>TJ</td> <td>Federal Taxpayer's Identification Number</td> </tr> </table>	HPI	Health Care Financing Administration National Provider Identifier	SY	Social Security Number	TJ	Federal Taxpayer's Identification Number
HPI	Health Care Financing Administration National Provider Identifier							
SY	Social Security Number							
TJ	Federal Taxpayer's Identification Number							

Segment: **DMG** Dependent Demographic Information
Position: 100
Loop: 2100D
Level: Detail
Usage: Optional
Max Use: 1
Notes: If the dependent's first and last names are not reported in the NM1 segment, the dependent's date of birth (DMG02) is required in this segment for subscriber matching.

Segment: **EQ** Dependent Eligibility or Benefit Inquiry Information
Position: 130
Loop: 2110D
Level: Detail
Usage: Required
Max Use: 1
Notes: Please see the processing guidelines for further explanation of the use of this loop.

Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>
<u>Des.</u>	<u>Element</u>	
EQ01	1365	Service Type Code

Information Source will return benefits only for selected service types. Service types '30', '35', '88', and 'AL' will be considered as requests for coverage information only. Detailed benefits for these services will not be returned in the response.

1	Medical Care	74	Private Duty Nursing
2	Surgical	75	Prosthetic Device
3	Consultation	76	Dialysis
4	Diagnostic X-Ray	77	Otological Exam
5	Diagnostic Lab	78	Chemotherapy
6	Radiation Therapy	79	Allergy Testing
7	Anesthesia	80	Immunizations
8	Surgical Assistance	81	Routine Physical
9	Other Medical	82	Family Planning
10	Blood Charges	83	Infertility
11	Used Durable Medical Equipment	84	Abortion
12	Durable Medical Equipment Purchase	85	AIDS
13	Ambulatory Service Center Facility	86	Emergency Services
14	Renal Supplies in the Home	87	Cancer
15	Alternate Method Dialysis	88	Pharmacy
16	Chronic Renal Disease (CRD) Equipment	89	Free Standing Prescription Drug
17	Pre-Admission Testing	90	Mail-Order Prescription Drug
18	Durable Medical Equipment Rental	91	Brand-Name Prescription Drug
19	Pneumonia Vaccine	92	Generic Prescription Drug
20	Second Surgical Opinion	93	Podiatry
21	Third Surgical Opinion	94	Podiatry - Office Visits
22	Social Work	95	Podiatry - Nursing Home Visits
23	Diagnostic Dental	96	Professional (Physician)
24	Periodontics	97	Anesthesiologist
25	Restorative	98	Professional (Physician) Visit - Office
26	Endodontics	99	Professional (Physician) Visit - Inpatient

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27	Maxillofacial Prosthetics	A0	Professional (Physician) Visit - Outpatient
28	Adjunctive Dental Services	A1	Professional (Physician) Visit - Nursing Home
30	Health Benefit Plan Coverage	A2	Professional (Physician) Visit - Skilled Nursing Facility
32	Plan Waiting Period	A3	Professional (Physician) Visit - Home
33	Chiropractic	A4	Psychiatric
34	Chiropractic Office Visits	A5	Psychiatric - Room and Board
35	Dental Care	A6	Psychotherapy
36	Dental Crowns	A7	Psychiatric - Inpatient
37	Dental Accident	A8	Psychiatric - Outpatient
38	Orthodontics	A9	Rehabilitation
39	Prosthodontics	AA	Rehabilitation - Room and Board
40	Oral Surgery	AB	Rehabilitation - Inpatient
41	Routine (Preventive) Dental	AC	Rehabilitation - Outpatient
42	Home Health Care	AD	Occupational Therapy
43	Home Health Prescriptions	AE	Physical Medicine
44	Home Health Visits	AF	Speech Therapy
45	Hospice	AG	Skilled Nursing Care
46	Respite Care	AH	Skilled Nursing Care - Room and Board
47	Hospital	AI	Substance Abuse
48	Hospital - Inpatient	AJ	Alcoholism
49	Hospital - Room and Board	AK	Drug Addiction
50	Hospital - Outpatient	AL	Vision (Optometry)
51	Hospital - Emergency Accident	AM	Frames
52	Hospital - Emergency Medical	AN	Routine Exam
53	Hospital - Ambulatory Surgical	AO	Lenses
54	Long Term Care	AQ	Nonmedically Necessary Physical
55	Major Medical	AR	Experimental Drug Therapy
56	Medically Related Transportation	BA	Independent Medical Evaluation
57	Air Transportation	BB	Partial Hospitalization (Psychiatric)
58	Cabulance	BC	Day Care (Psychiatric)
59	Licensed Ambulance	BD	Cognitive Therapy
60	General Benefits	BE	Massage Therapy
61	In-vitro Fertilization	BF	Pulmonary Rehabilitation
62	MRI/CAT Scan	BG	Cardiac Rehabilitation
63	Donor Procedures	BH	Pediatric
64	Acupuncture	BI	Nursery
65	Newborn Care	BJ	Skin
66	Pathology	BK	Orthopedic
67	Smoking Cessation	BL	Cardiac
68	Well Baby Care	BM	Lymphatic
69	Maternity	BN	Gastrointestinal
70	Transplants	BP	Endocrine
71	Audiology Exam	BQ	Neurology
72	Inhalation Therapy	BR	Eye
73	Diagnostic Medical	BS	Invasive Procedures

EQ02 C003 Composite Medical Procedure Identifier
C00301 235 Product/Service ID Qualifier

HCPCS (HC), American Dental Association (AD) or CPT (CJ) codes are accepted.

AD	American Dental Association Codes
CJ	Current Procedural Terminology (CPT) Codes
HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

Segment: **III** Dependent Eligibility or Benefit Additional Inquiry Information
Position: 170
Loop: 2110D
Level: Detail
Usage: Optional
Max Use: 10
Notes: Two repeats of the III--Subscriber Eligibility or Benefit Inquiry Information are required. One repeat must contain the ICD-9 Principle Diagnosis Code, and the other must contain the Facility Type Code.

1) Diagnosis Code: Information Source will use only one diagnosis code to determine benefits. When two or more diagnosis codes are reported using both the Principle Diagnosis ('BK') and Diagnosis ('BF') qualifiers, the principle diagnosis code qualified by 'BK' will be used when determining benefits.

2) Facility Type Code: Place of service is required in order to determine benefits. If a place of service is not reported, BlueCross BlueShield of South Carolina will default the place of service based upon information in the system's provider files, and return benefits based upon the default.

If a place of service is implied in a service type (EQ01) and a conflicting place of service code is reported in this segment, the implied place of service will be used to determine benefits. For example, when service type 48 (hospital--inpatient) is reported as the service type in EQ01, and the facility type code in this segment is reported as 12 (home), the benefits will be based upon inpatient hospital--the service type's implied place of service.

Data Element Summary

Ref.	Data	Name
<u>Des.</u>	<u>Element</u>	<u>Code List Qualifier Code</u>
III01	1270	Code List Qualifier Code
		BF Diagnosis
		BK Principal Diagnosis
		ZZ Mutually Defined
III02	1271	Industry Code
		<i>Facility Type Code</i>
1	Pharmacy	32 Nursing Facility
2	Unassigned	33 Custodial Care Facility
3	School	34 Hospice
4	Homeless Shelter	41 Ambulance--Land
5	Indian Health Service Free-Standing Facility	42 Ambulance--Air or Water
6	Indian Health Service Provider-Based Facility	49 Independent Clinic
7	Tribal 638 Free-standing Facility	50 Federally Qualified Health Center
8	Tribal 638 Provider-based Facility	51 Inpatient Psychiatric Facility
9	Prison-Correctional Facility	52 Psychiatric Facility--Partial Hospitalization
11	Office	53 Community Mental Health Center
12	Home	54 Intermediate Care Facility/Mentally Retarded
13	Assisted Living Facility	55 Residential Substance Abuse Treatment Facility
14	Group Home	56 Psychiatric Residential Treatment Center
15	Mobile Unit	57 Non-residential Substance Abuse Treatment Facility
20	Urgent Care Facility	60 Mass Immunization Center
21	Inpatient Hospital	61 Comprehensive Inpatient Rehabilitation Facility
22	Outpatient Hospital	62 Comprehensive Outpatient Rehabilitation Facility

Continued on next page

23	Emergency Room--Hospital	65	End-Stage Renal Disease Treatment Facility
24	Ambulatory Surgical Center	71	Public Health Clinic
25	Birth Center	72	Rural Health Clinic
26	Military Treatment Facility	81	Independent Laboratory
31	Skilled Nursing Facility	99	Other Place of Service