



What you need to know about electronic eligibility verification

How will implementing electronic eligibility verification improve your practice's workflow?

- Do you find out after filing a claim that the patient is not covered by the health plan?
- Do you spend a lot of time re-keying patient information for each transaction?
- Have you ever had a claim rejected for incorrectly keyed Member ID, Name or Date of Birth information?
- Do you wait until the claim is paid to determine if you should collect a co-payment or deductible?

If you answered "Yes" to any of these questions, you should consider using the Health Insurance Portability and Accountability Act (HIPAA)-mandated Accredited Standards Committee (ASC) X12 270/271 health care eligibility benefit inquiry and response transactions (eligibility request and response).¹

Why should my practice implement electronic eligibility verification now?

Take a look at the following changes in the eligibility request and response transactions and operating rules that may be beneficial for your practice. For example, your practice will now receive the patient's portion of the financial responsibility, including co-payment, co-insurance and patient-specific remaining deductible. This information can help your practice estimate patient costs *before* treatment decisions are made, price claims, and collect patient deductibles and co-insurance before patients leave the office, rather than waiting weeks or months for the health insurer's explanation of benefits (EOBs). Access an [AMA toolkit](#) to learn how to collect payment from patients at the time of service.

AMA practice tip: Improve practice efficiencies and save money

Your practice 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.

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

¹ Visit Washington Publishing Company at www.wpc-edi.com/reference/registry to obtain a complete listing of HIPAA-mandated ASC X12 transactions.
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Multiple search options

Search options

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

Operating rules enhance the eligibility response transaction even further

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 www.cagh.org/CORE_organizations.php to see if health insurers you work with are on the list:

These HIPAA mandated operating rules require additional functionality already available in the ASC X12 5010 270/271 eligibility benefit inquiry and response transactions but were optional for health insurers under HIPAA.

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 – Office, UC – Urgent Care.
- The health insurer may, at its discretion, return co-payment, co-insurance information and base deductible information for the following services specified in EB03-1365: 1 – 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 1 – Medical Care, 33 – Chiropractic, 35 – Dental Care, 47 – Hospital, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 88 – Pharmacy, 98 – Professional (Physician) Visit – Office, AL – Vision (Optometry), MH – Mental Health and UC – Urgent Care.

Additional resources on electronic eligibility verification

Access the [AMA toolkit](#) on electronic eligibility verification for additional resources to help your practice use these transactions, including, "[Considerations for processing electronic transactions in the physician practice](#)," "[Questions to ask a health insurer before enrolling in an electronic transactions program](#)," and more.

HIPAA EDI Integrated Electronic Health Care Transaction Flow

*Accredited Standards Committee (ASC) X12

