Washington State Medicaid

Payer Initiated Eligibility/Benefit (PIE) Transaction
(A Non-HIPAA Transaction)

Deficit Reduction Act (DRA) Companion Guide to the
ASC X12 Version 005010X279A1 Technical Report Type 3

DRA Companion Guide Version 1.0

Preface

This Companion Guide represents an electronic transaction that can be used by health plans to transmit eligibility and benefit information to Washington State Medicaid.

This Medicaid DRA Companion Guide is to assist State Medicaid agencies and payers in implementing the Payer Initiated Eligibility/Benefit (PIE) Transaction. This DRA Companion Guide is written to support Accredited Standards Committee (ASC) X12N 005010X279 Implementation Guide.

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1 INTRODUCTION

Federal law requires States to identify and obtain payment from third party entities that are legally responsible to pay claims primary to Medicaid. To enhance States‘ ability to identify legally liable third parties, the Deficit Reduction Act of 2005 (DRA) required States to pass laws imposing requirements on health plans, as a condition of doing business in the State, to provide plan eligibility information to the State.

The purpose of this Companion Guide is to assist payers in providing health plan eligibility and coverage information to State Medicaid programs. The Centers for Medicare & Medicaid Services developed the Payer Initiated Eligibility/Benefit (PIE) Transaction described in this Guide which can be used to meet the DRA requirements.

The official version of the DRA Companion Guide can be found at: www.cms.hhs.gov/ThirdPartyLiability/DRA/CompanionGuide. The language in the official Guide must not be altered, except to include State-specific information.

The DRA also clarified the definition of health insurer to include self-insured plans, managed care organizations, pharmacy benefit managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. Other parties include such entities as third party administrators, fiscal intermediaries, and managed care contractors, who administer benefits on behalf of the risk-bearing sponsor (e.g., an employer with a self-insured health plan). Health insurers will be referred to as ‘payers’ throughout this document.

1.1 SCOPE

This DRA Companion Guide is issued by Washington State Medicaid to assist payers in providing the type of information that is needed to comply with the DRA. The Guide focuses on the exchange of data from payers to Washington State Medicaid.

1.2 OVERVIEW

The Secretary adopted the following transmission format that was developed by Accredited Standards Committee (ASC) for conducting eligibility and benefit information transactions between the Medicaid agency, or its agent, and other payers:

- ASC X12 270/271 Health Care Eligibility/Benefit Inquiry and Response Technical Report Type 3 Version 005010X279 (hereafter referred to as Version 5010)

The Payer Initiated Eligibility/Benefit (PIE) Transaction will be used to provide Washington State Medicaid with a listing that identifies plan members' eligibility for health coverage and their associated benefits. The PIE Transaction was developed to deliver membership and benefit information in one single, unsolicited transaction. The PIE Transaction uses the same identifiers as the ASC X12 271 response transaction and therefore mirrors the format of the 271 transaction. The purpose of this DRA Companion Guide is to provide a standardized format for the PIE Transaction information. The information supplied on the PIE Transaction is to be as comprehensive as possible, with beginning and end dates and including other coverage, if available. The provided information will be used to match to the Medicaid databases. For this purpose, a required key data element is the Social Security Number. If the Social Security Number is not available, other key identifiers may be used.

The DRA strengthens States' ability to obtain payments from health insurers by requiring States to have laws in effect that require health insurers to make payment as long as the claim is submitted by the Medicaid agency within 3 years from the date on which the item or service was furnished. For this reason, Washington State Medicaid may require 3 years' worth of data.

The identifiers provided by the payers on the PIE Transaction are also used to construct HIPAA-standard eligibility inquiries as well as claims. The specific use of these identifiers is described in Section 9 Transaction Specific Information. The PIE Transaction DRA Companion Guide represents, in part, the guidelines developed by the Secretary for use by Medicaid agencies and payers. These

guidelines will provide Medicaid agencies with the information needed to bill the appropriate payers.

1.3 REFERENCES

- Deficit Reduction Act (DRA) of 2005 Section 6035
- CMS Guidance on the DRA, Section 6035
  http://www.cms.hhs.gov/smdl/downloads/SMD121506.pdf
  http://www.cms.hhs.gov/smdl/downloads/SMD121506QandA.pdf
  http://www.cms.gov/smdl/downloads/SMD10011.pdf
- 45 CFR Parts 160, 162, and 164 Health Insurance Reform: Security Standards; Final Rule dated February 20, 2003
  http://www.cms.hhs.gov/SecurityStandard/Downloads/securityfinalrule.pdf.
- ASC X12 270/271 Health Care Eligibility/Benefit Inquiry and Response Technical Report Type 3 Version 005010X279 (Version 5010)

2 GETTING STARTED

2.1 WORKING WITH WASHINGTON STATE MEDICAID

Please use the following contact information to coordinate the process of establishing a working relationship with Washington State Medicaid:

EDI CUSTOMER SERVICE

- Email: hipaa-help@hca.wa.gov
  - All emails result in the assignment of a Ticket Number for problem tracking

- Information required for initial email:
    - Name
    - Phone Number
    - Email Address
    - 7 digit Provider One ID Number
    - NPI
    - HIPAA File Name
    - Detailed Description of Issue
    - Transaction Type

- Information required for follow up call(s):
    - Assigned Ticket Number

2.2 TRADING PARTNER REGISTRATION

1. Trading Partner Agreements are available for download at https://www.hca.wa.gov/medicaid/Pages/index.aspx

2. The Trading Partner completes the Trading Partner Agreement and submits the signed agreement to:

   HCA HIPAA EDI Department
   PO Box 45562
   Olympia, WA 98504-5562

3. Please use the following contact information to coordinate all trading partner registration for Washington State Medicaid:

   http://www.hca.wa.gov/pages/contact.aspx

   - Click on Medicaid
   - Click on Webform
   - Click on Provider
   - Input all the necessary information
     - Select Provider Enrollment in the Select Topic dropdown
     - Click on Submit Request when done

4. Upon completion of TPA enrollment, the trading partner will be assigned a ProviderOne ID

3 TESTING WITH THE PAYER

Washington State Medicaid will supply payers with testing details such as access to submit test transactions, procedures for confirming successful transmission and processing, and procedures for submitting production transactions. Please use the contact information in section 2.1 to coordinate testing with Washington State Medicaid:

3.1 Testing Process

1. The trading partner submits all HIPAA test files through the ProviderOne Secure File Transfer Protocol (SFTP).

    a. SFTP URL: sftp://ftp.waproviderone.org/

The trading partner downloads acknowledgements for the test file from the ProviderOne SFTP HIPAA ACK folder.

If the ProviderOne system generates a positive TA1 and positive 999 acknowledgements, the file is successfully accepted. The trading partner is then approved to send PIE files in production.

If the test file generates a negative TA1 or negative 999 acknowledgments, then the submission is unsuccessful and the file is rejected. The trading partner needs to resolve all the errors reported on the negative TA1 or negative 999 and resubmit the file for test. Trading partners will continue to test in the testing environment until they receive a positive TA1 and positive 999.

Completion of the testing process must occur prior to submitting electronic transactions in production to Washington State Medicaid. Testing is conducted to ensure the following levels of HIPAA compliance:

1. Level 1 – Syntactical integrity: Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 or NCPDP syntax, and compliance with X12 and NCPDP rules.

2. Level 2 – Syntactical requirements: Testing for HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. It will also include testing for HIPAA required or intra-segment situational data elements, testing for non-medical code sets as laid out in the Implementation Guide, and values and codes noted in the Implementation Guide via an X12 code list or table.

3.2 SFTP Set-Up

Trading partners can email hipaa-help@hca.wa.gov for information on establishing a SFTP account

3.3 SFTP Directory

There are two categories of SFTP folders:

1. TEST – Trading Partners should submit and receive their test files under this root folder

2. PROD – Trading Partner's should submit and receive their production files under this root folder

Within each main SFTP folder are 6 subfolders:

1. HIPAA_Inbound - This folder should be used to drop the HIPAA Inbound files that needs to be submitted to Washington State Medicaid

2. HIPAA_Ack - Trading partner should look for acknowledgements to the files submitted in this folder. TA1, 999 and custom report will be available for all the files submitted by the Trading Partner

3. HIPAA_Outbound – HIPAA outbound transactions generated by Washington State Medicaid will be available in this folder

4. HIPAA_Error – Any inbound file that is not processed, HIPAA compliant, or is not recognized by ProviderOne will be moved to this folder

5. HIPAA Working – There is no functional use for this folder at this time

6. HIPAA ReadMe – Important messages regarding password updates, outage information and general SFTP messages will be available within this folder.

3.4 SFTP File Naming Convention

For PIE transactions:

HIPAA.<TPId>.<datetimestamp>.<originalfilename>.<dat>

Example of file name: HIPAA.123456789.010120132100.PIE.dat

<TPId> is the Trading Partner Id/ProviderOne ID

<datetimestamp> is the Date Timestamp

<originalfilename> is the original file name which is submitted by the trading partner.

All HIPAA submitted files MUST BE **.dat** files or they will not be processed

3.5 General Information

For PIE transactions:

Transmission sizes are limited based on two factors:

Number of Segments/Records allowed by HCA

HCA file size limitations

HCA accepts PIE transaction files with single ISA/IEA and GS/GE envelopes. PIE transactions (with their limit of 5,000 repeats of Loop 2000C within an ST/SE envelop), can have multiple ST/SE envelops within the same GS/GE envelope.

HCA limits a file size to 10 MB while uploading PIE files through SFTP.

4 CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

Payers should use the contact information identified in Section 2. Getting Started to determine the appropriate process flows, transmission and re-transmission procedures, communications protocol and security specifications. All transmission must be secure in accordance with *45 CFR Parts 160, 162, and 164 Health Insurance Reform: Security Standards; Final Rule dated February 20, 2003*, which can be accessed via the following:http://www.cms.hhs.gov/SecurityStandard/Downloads/securityfinalrule.pdf

5 CONTACT INFORMATION

Once trading partner agreements have been completed, access has been granted, and production transmissions have begun, the contact information in section 2 should be used for issues that arise.

6 CONTROL SEGMENTS / ENVELOPES

The PIE Transaction conforms to ASC X12 Control Segments / Envelopes (ISA-IEA, GS-GE, and ST-SE) for Version 5010. Since files will be transmitted infrequently, files sizes will be large and will contain more than the usual number of records. Qualifiers to be used in the Sender Interchange ID Qualifier (ISA05) and Receiver Interchange ID Qualifier (ISA07) and identifiers to be used in Interchange Sender ID (ISA06) and Interchange Receiver ID (ISA08) will be specified in Section 9 Transaction Specific Information.

7 ACKNOWLEDGEMENTS AND/OR REPORTS

A single positive ASC X12acknowledgement will be sent back to payers indicating that the transmission was received. For Version 5010, an implementation acknowledgement (999) will be sent. If a positive acknowledgement is not received within 24 hours, resend the file once only. If a positive acknowledgement is still not received, contact the Washington State Medicaid EDI Customer Service. Washington State Medicaid will not reply indicating which subscribers matched the Washington State Medicaid database.

8 TRADING PARTNER AGREEMENTS

The sharing of information received from the payers is limited to use by Washington State Medicaid and its vendor under contract with the Medicaid agency for purposes of data matching and coordination of benefits. The information in Section 2.2 Trading Partner Registration will be used to coordinate trading partner agreements.

9 TRANSACTION SPECIFIC INFORMATION

Washington State Medicaid requires that all Eligibility or Benefit Information (EB segments) that are appropriate to the plan be included in the Subscriber Eligibility or Benefit Information loop (2110C); likewise the Dependent Eligibility or Benefit Information loop (2110D) is used to provide dependent related information. Payers should provide qualifiers that are appropriate to their coverage including, but not limited to, Eligibility Benefit Information (EB01) and Service Type Code (EB03). Washington State Medicaid requires a Subscriber Eligibility/Benefit date and Dependent Eligibility/Benefit Date (DTP segment) in the Subscriber Eligibility or Benefit Information loop (2110C) and Dependent Eligibility or Benefit Information loop (2110D) to specify actual start and end dates of coverage by subscriber or dependent. Qualifiers and dates sent in the PIE Transaction will be used by Washington State Medicaid to determine whether it is appropriate to submit a claim and may be used on 270s in the 270/271 Eligibility Transaction exchange.

In the table below Washington State Medicaid identifies various data components (i.e. loops, segments, elements or qualifiers) as —"Required when available". These components may be needed for subsequent EDI transactions. There are two primary ways a component may be used for subsequent EDI transactions:

Washington State Medicaid requires the component in order to support matching to the Washington State Medicaid database, thus ensuring that allocations of payment responsibility and subsequent claims submissions are appropriate.

When values appear in the Codes column, these values are the only values allowed. If no values are specified for a coded element, all valid codes appearing in the 270/271 Implementation Guide is allowed.

At this time Washington State Medicaid supports Version 5010 only

Table 1 represents the specific information to be included in a PIE Transaction. All specifications must be adhered to unless both Washington State Medicaid and the payer mutually agree to any adjustments.

TABLE 1 – PIE TRANSACTION SPECIFIC INFORMATION

Page # 5010	Loop ID	Reference	Name	Codes	Length	Notes/Comments
Interchange Control Header						
App. C	Envelope	ISA01	Authorization Information Qualifier		2/2	Required. Please use ‘00’
App. C	Envelope	ISA03	Security Information Qualifier		2/2	Required. Please use ‘00’
App. C	Envelope	ISA05	Interchange ID Qualifier		2/2	Required. Please use ‘ZZ’
App. C	Envelope	ISA06	Interchange Sender ID			Required. Health Plan 9 digit ProviderOne ID
App. C	Envelope	ISA07	Interchange ID Qualifier		2/2	Required. Please use ‘ZZ’
App. C	Envelope	ISA08	Interchange Receiver ID		15/15	Required. Please use ‘77045’
App. C	Envelope	ISA11	Interchange Control Standards Identifier		81/1	Required. Please Use ‘^’
App. C	Envelope	ISA16	Component Element Separator		1/1	Required. Please use ':'
Functional Group Header						
App. C	Envelope	GS01	Functional Identifier Code		2/2	Required. Please use 'HB'
App. C	Envelope	GS02	Application Sender’s Code		2/15	Required. Health Plan 9 digit ProviderOne ID
App. C	Envelope	GS03	Application Receiver’s Code		2/15	Required. Please use '77045'
App. C	Envelope	GS08	Version / Release / Industry Identifier Code		1/2	Required. Please use ‘005010X279A1'
Transaction Set Header						

209	Envelope	ST01	Transaction Set Identifier Code		3/3	Required. Please use '271'
218	2100A	NM1	Information Source Name			Required
220	2100A	NM109	Identification Code		2/80	Required. Required. Health Plan 9 digit ProviderOne ID Should be identical to ISA06 and GS02
232	2100B	NM1	Information Receiver Name			Required
233	2100B	NM103	Information Receiver Last Name		1/60	Required. Please use 'WA STATE MEDICAID'
235	2100B	NM109	Identification Code		2/80	Please use '77045'.
249	2100C	NM1	Subscriber Name			Required
250	2100C	NM103	Subscriber Last Name		1/35	Required
250	2100C	NM104	Subscriber First Name		1/25	Required
250	2100C	NM105	Subscriber Middle Name or Initial		1/25	Required when available.
251	2100C	NM108	Identification Code Qualifier	MI	1/2	Required
251	2100C	NM109	Identification Code		2/80	Required. Send Member Identification Number or unique identifier required by the payer on claims submissions.
253	2100C	REF	Subscriber Additional Identification			Required. Send a REF segment for each identifier available to optimize matching to the Medicaid agency database. The first occurrence of the REF additional information must be —SY Social Security Number as defined below.
254	2100C	REF01	Reference Identification Qualifier		2/3	

			Social Security Number	SY		Required. Send the —SY Social Security Number in the first REF segment.
256	2100C	REF02	Subscriber Supplemental Identifier		1/30	
			Social Security Number		10	Required. Send the Social Security Number in the first REF segment. If the Social Security Number is not available, send —999999999.
257	2100C	N3	Subscriber Address			Required when available.
257	2100C	N301	Subscriber Address Line		1/55	Required when available.
258	2100C	N302	Subscriber Address Line		1/55	Required when the second address line exists.
259	2100C	N4	Subscriber City, State, Zip Code			Required when available.
260	2100C	N401	Subscriber City Name		2/30	Required when available.
260	2100C	N402	Subscriber State Code		2/2	Required when available.
260	2100C	N403	Subscriber Postal Zone or Zip Code		3/15	Required when available.
268	2100C	DMG	Subscriber Demographic Information			Required
269	2100C	DMG02	Subscriber Birth Date		1/35	Required
269	2100C	DMG03	Subscriber Gender Code		1/1	Required
284	2100C	DTP	Subscriber Date			Required. Send the Date Time Period that reflects the total time period covered by the PIE Transaction.
284	2100C	DTP01	Date Time Qualifier	307	3/3	Required
284	2100C	DTP02	Date Time Period Qualifier	RD8	2/3	Required
284	2100C	DTP03	Date Time Period		1/35	Required. Send the date range that reflects the total time period covered by the

						PIE Transaction. For instance, if the information source is providing data covering the last 3 years, this date range would show a 3 year time period ending today even if the subscriber was only covered during the last year.
289	2110C	EB	Eligibility or Benefit Information			Required. Send all EB segments and EB03 (Service Type Code) qualifiers needed in order to fully describe the coverage. Do not send inactive coverage (EB01=6). Service Type Codes submitted need to align with the CAQH CORE Phase 2 Operating Rule 260.
309	2110C	HSD	Health Care Services Delivery			Required when needed to fully define the eligibility or benefit represented by the preceding EB segment.
314	2110C	REF	Subscriber Additional Information			Required when additional identifiers are required on claims relating to the eligibility or benefit represented by the preceding EB segment.
317	2110C	DTP	Subscriber Eligibility/Benefit Date			Required. Send the Date Time Period that describes the eligibility or benefit represented by the preceding EB segment.

317	2110C	DTP01	Date Time Qualifier	307	3/3	Required
318	2110C	DTP02	Date Time Period Format Qualifier	RD8	2/3	Required
318	2110C	DTP03	Eligibility or Benefit Date Time Period		1/35	Required. Send the Date Time Period that represents the actual start and end of the eligibility or benefit represented by the preceding EB segment. If the eligibility or benefit is open-ended (i.e., no end date), send a date range with an ending date in the future, but not farther in the future than 12/31/2099.
329	2120C		Subscriber Benefit Related Entity			subscriber's benefit- related entity information (such as another information source) is available, e.g. a pharmacy benefit manager contracted by the information source.
335	2120C	N3	Subscriber Benefit Related Entity Address			Required when available
336	2120C	N4	Subscriber Benefit Related Entity City, State, Zip Code			Required when available
347	2000D	HL	Dependent Level			Refer to the 5010 Implementation Guides for usage of the dependent loop.
354	2100D	NM1	Dependent Name			Required
355	2100D	NM103	Dependent Last Name		1/35	Required
355	2100D	NM104	Dependent First Name		1/25	Required
355	2100D	NM105	Dependent Middle Name		1/25	Required when Available
357	2100D	REF	Dependent			Required. Send

			Additional Information			a REF segment for each identifier available in the information source database to optimize matching to the Medicaid agency database. The first occurrence of the REF additional information must be —SY Social Security Number as defined below.
358	2100D	REF01	Dependent Reference Identification Qualifier		2/3	
			Social Security Number	SY		Required. Send the —SY Social Security Number in the first REF segment.
360	2100D	REF02	Dependent Supplemental Identifier		1/30	
			Social Security Number		10	Required. Send the Social Security Number in the first REF segment. If the Social Security Number is not available, send —999999999
361	2100D	N3	Dependent Address			Required when available.
361	2100D	N301	Dependent Address Line		1/55	Required when available.
362	2100D	N302	Dependent Address Line		1/55	Required when the second address line exists.
364	2100D	N4	Dependent City, State, Zip Code			Required when available.
364	2100D	N403	Dependent Postal Zone or ZIP Code		3/15	Required when available.
372	2100D	DMG	Dependent Demographic Information			Required
373	2100D	DMG02	Dependent Birth Date		1/35	Required
373	2100D	DMG03	Dependent Gender Code		1/1	Required
375	2100D	INS	Dependent			Required when

			Relationship			available.
376	2100D	INS01	Insured Indicator	N	1/1	Required
376	2100D	INS02	Individual Relationship Code		2/2	Required
377	2100D	INS17	Birth Sequence Number		1/9	Required when available.
388	2100D	DTP	Dependent Date			Required. Send the Date Time Period that reflects the total time period covered by the PIE Transaction.
388	2100D	DTP01	Date Time Qualifier	307	3/3	Required
388	2100D	DTP02	Date Time Period Format Qualifier	RD8	2/3	Required
388	2100D	DPT03	Date Time Period		1/35	Required. Send the date range that reflects the total time period covered by the PIE Transaction. For instance, if the information source is providing data covering the last 3 years, this date range would show a 3 year time period ending today even if the dependent was only covered during the last year.
394	2110D	EB	Eligibility or Benefit Information			Required. Send all EB segments and EB03 (Service Type Code) qualifiers needed in order to fully describe the coverage. Do not send inactive coverage (EB01=6). Service Type Codes submitted need to align with the CAQH CORE Phase 2 Operating Rule 260.

413	2110D	HSD	Health Care Services Delivery			Required when needed to fully define the eligibility or benefit represented by the preceding EB segment.
417	2110D	REF	Dependent Additional Information			Required when additional identifiers are required on claims relating to the eligibility or benefit represented by the preceding EB segment.
421	2110D	DTP	Dependent Eligibility / Benefit Date			Required. Send the Date Time Period that describes the eligibility or benefit represented by the preceding EB segment.
421	2110D	DTP01	Date Time Qualifier	307	3/3	Required
421	2110D	DTP02	Date Time Period Format Qualifier	RD8	2/3	Required
421	2110D	DTP03	Eligibility or Benefit Date Time Period		1/35	Required. Send the Date Time Period that represents the actual start and end of the eligibility or benefit represented by the preceding EB segment. If the eligibility or benefit is open-ended (i.e., no end date), send a date range with an ending date in the future, but not farther in the future than 12/31/2099.
433	2120D		Dependent Benefit Related Entity			Required when a dependent‘s benefit- related entity information (such as another information source) is available, e.g. a pharmacy benefit manager

						contracted by the information source.
438	2120D	N3	Dependent Benefit Related Entity Address			Required when available.
439	2120D	N4	Dependent Benefit Related Entity City, State, Zip Code			Required when available.

Appendix A Business Scenarios

The PIE Transaction will be submitted on a predetermined schedule and frequency as agreed upon with Washington State Medicaid. The Health Care Eligibility Benefit Inquiry and Response (270/271) may be used to clarify or update coverage information as part of the Medicaid coordination of benefits and cost recovery processes. For more information about the business context and the benefits to payers and Medicaid agencies, visit the following: www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery

Appendix B Change Summary

TABLE 2 – CHANGE SUMMARY

1.0	06/19/2013	Washington State Medicaid	Initial Version
2.0	12/03/2018	Washington State Medicaid	Updated Hyperlinks

APPENDIX C – GLOSSARY AND ACRONYMS

TABLE 3 – GLOSSARY

Term	Definition
Information Receiver	In the case of the PIE Transaction, the information receiver is Washington State Medicaid.
Payer	In this DRA Companion Guide, payer refers to the —health insurer Section 6035 clarified the definition of health insurer to include self-insured plans, managed care organizations, pharmacy benefit managers and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. Other parties include such entities as third party administrators, fiscal intermediaries, and managed care contractors, who administer benefits on behalf of the risk-bearing sponsor (e.g., an employer with a self-insured health plan).

TABLE 4 - ACRONYMS

Acronym	Definition
2100C	Subscriber loop
2110C	Subscriber Eligibility or Benefit Information loop
2120C	Subscriber Benefit Related Entity loop
2100D	Dependent loop
2110D	Dependent Eligibility or Benefit Information loop
2120D	Dependent Benefit Related Entity loop
270	A HIPAA-compliant transaction used to request information about eligibility for benefits.
271	A HIPAA-compliant transaction used to return information about a subscriber‘s eligibility for benefits.
997	A functional acknowledgement. An ASC X12N standard transaction used either to acknowledge receipt of a 270 transaction or to reject a transaction based on failure in the content of the request.
999	An implementation acknowledgement. An ASC X12 standard transaction used to acknowledge receipt of a batch 270.
ASC X12	ASC X12 is a standard for EDI that is sponsored by the American National Standards Institute Accredited Standards Committee. It is a selected standard for HIPAA-compliant transactions.
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act
DTP	Date or Time or Period—this segment is used to provide a date or date range in an ASC X12 transaction. This segment can be found in multiple places in the transaction.
EB	Eligibility or Benefit Information—This segment supplies eligibility and benefit information. It can be used in both the subscriber and dependent loops.
EB01	Eligibility or Benefit Information Code identifies eligibility or benefit information provided in the EB segment.
EB03	Service Type Code classifies the type of service described in the EB

	segment.
EDI	Electronic Data Interchange is a subset of Electronic Commerce. It is a set of standardized electronic business documents, which are exchanged in agreed-upon formats.
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Title II). Title II of HIPAA, known as the Administrative Simplification provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for covered entity providers, health insurance plans, and clearing houses. The Administrative Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of EDI in the U.S. health care system.
ISA	Interchange Control Header
ISA04	Security Information (ISA)
ISA05	ISA05 Interchange ID Qualifier (ISA) designates the system/method of code structure used to designate the Sender ID element being qualified.
ISA06	Interchange Sender ID (ISA)
ISA07	ISA07 Interchange ID Qualifier (ISA) designates the system/method of code structure used to designate the Receiver ID element being qualified.
ISA08	Interchange Receiver ID (ISA)
PIE	Payer Initiated Eligibility/Benefit—This is the transaction developed by CMS that can be used by the Medicaid agencies to obtain eligibility and benefit information from payers in a single unsolicited transaction.
X12	X12 is a standard for EDI that is sponsored by the American National Standards Institute Accredited Standards Committee. The proper designation is ASC X12. It is a selected standard for HIPAA-compliant transactions.
X12N	X12 is a standard for EDI that is sponsored by the American National Standards Institute Accredited Standards Committee. It is a selected standard for HIPAA-compliant transactions. The —N‖ designates the Insurance subcommittee. The —N‖reference has been dropped in more recent standards.