ADDENDUM 10

Query and Response file
270 & 271 Companion Guide

ADMINISTRACION DE
SEGUROS DE SALUD

25 - 00003

Contrato Número

Puerto Rico Medicaid Management Information System Services (PRMMIS)

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3)
Implementation Guides
Based on ASC X12 Version 005010X279A1

270/271 Eligibility & Benefit Inquiry and Response

Companion Guide Version Number: 1.3

August 2023

ADMINISTRACION DE
SEGUROS DE SALUD

25 - 00003

Contrato Número

Disclosure Statement

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (communications/connectivity instructions), and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every Companion Guide. The components may be published as separate documents or as a single document.

The communications/connectivity component is included in the Companion Guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The transaction instruction component is included in the Companion Guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

Contrato Número

Preface

This Companion Guide to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with PRMMIS. Transmissions based on this Companion Guide, used in tandem with the TR3, also called the 270/271 Health Care Eligibility and Benefit Inquiry and Response (270/271) ASC X12N (version 005010X279A1), are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

Contrato Número

(This page was intentionally left blank.)

Table of Contents

ADMINISTRACION DE
SEGUROS DE SALUD

25 - 00003

Contrato Número

1 INTRODUCTION

This section describes how TR3, also called 270/271 ASC X12N (version 005010X279A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that PRMMIS has information additional to the TR3. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guide's internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with PRMMIS.

In addition to the row for each segment, one or more additional rows are used to describe PRMMIS's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides. The table contains a Notes/Comments column to provide additional information from PRMMIS for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 9: Transaction Specific Information.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by PRMMIS.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

This Companion Guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 270/271 (referred to as Eligibility and Benefit in the rest of this document) for the purpose of submitting eligibility and benefit inquiries electronically. This Companion Guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this Companion Guide is to provide trading partners with a guide to communicate PRMMIS-specific information required to successfully exchange transactions electronically with PRMMIS interChange. The instructions in this Companion Guide are not intended to be stand-alone requirements documents. This Companion Guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The information contained in this Companion Guide applies to PRMMIS, which includes the following programs: TXIX or CHIP or CWLTH and Medicaid managed care programs. All of these programs use PRMMIS interChange for processing.

PRMMIS interChange will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain PRMMIS-specific information, though processed, may be denied. For example, a compliant 270 inquiry (270) created with an invalid PRMMIS member identification number will be processed by PRMMIS but will be denied.

Refer to this Companion Guide first if there is a question about how PRMMIS processes a HIPAA transaction. For further information, contact the PRMMIS Electronic Data Interchange (EDI) Department at (833) 209-8326. This guide is intended as a resource to assist carriers with PRMMIS interChange in successfully conducting EDI of administrative health care transactions. This document provides instructions for enrolling as a PRMMIS interChange carrier, obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

Per HIPAA requirements, PRMMIS and all other covered entities must comply with the EDI standards for health care as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required under HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. Additionally, HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The HIPAA requirements serve to:
Create better access to health insurance.
Limit fraud and abuse.
Reduce administrative costs.

ADMINISTRACIÓN DE SEGUROS DE SALUD

25 - 00003

Contrato Número

This guide is designed to help those responsible for testing and setting up electronic eligibility transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to PRMMIS interChange. This guide supplements (but does not contradict) requirements in the ASC X12N 270/271 (version 005010X279A1) implementation. This information should be given to the carrier's business area to ensure that eligibility responses are interpreted correctly. This guide provides communications-related information a trading partner needs to enroll as a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with PRMMIS interChange.

This Companion Guide must be used in conjunction with the TR3 instructions. The Companion Guide is intended to assist trading partners in implementing electronic 270/271 transactions that meet PRMMIS interChange processing standards by identifying pertinent structural and data-related requirements and recommendations. Updates to this Companion Guide will occur periodically and new documents will be posted on PRMMIS LMS Puerto Rico LMS - Home.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 270/271 Health Care Eligibility and Benefit Inquiry and Response (version 005010X279A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company Web site at *www.wpc-edi.com/*.

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's information technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with PRMMIS interChange.

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange adoption has been proved to reduce the administrative burden on providers.

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

1.5 National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003 9

Contrato Número

The NPI replaces all payer-specific identification numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that will be allowed on these transactions.

PRMMIS has determined that all providers, except for personal care only providers, specialized medical vehicle providers, and blood banks, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. PRMMIS requires all health care providers to submit their NPI on electronic transactions.

1.6 Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. PRMMIS accepts the extended character set. Uppercase characters are recommended.

1.7 Acknowledgements

An accepted 999 Implementation Acknowledgement, rejected 999 Implementation Acknowledgement (with HTML file), or rejected TA1 InterChange Acknowledgement will be generated in response to all submitted files. Trading partners are responsible for retrieving acknowledgments from the PRMMIS Portal to determine the status of their files.

2 GETTING STARTED

2.1 Working with PRMMIS

This section describes how to interact with PRMMIS's EDI Department.

Before PRMMIS can process transactions, the submitter is required to obtain a trading partner ID, create a Portal user account, and complete Production Authorization testing. Additional information is provided in the next section of this Companion Guide. Trading partners should exchange electronic health care transactions with PRMMIS interChange via MoveIT. Each trading partner must successfully complete testing. Upon successful completion of testing, production transactions may be exchanged.

Reminder: Testers are responsible for the preservation, privacy, and security of data in their possession. While using production data that contains personal health information (PHI) to conduct testing, the data must be guarded and disposed of appropriately.

3 CONNECTIVITY WITH PRMMIS / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 270 transactions, along with various submission methods, security requirements, and exception handling procedures.

3.1 Batch Eligibility Benefit Inquiry and Response

The response to a batch eligibility transaction will consist of the following:

ADMINISTRACION DE SEGUROS DE SALUD

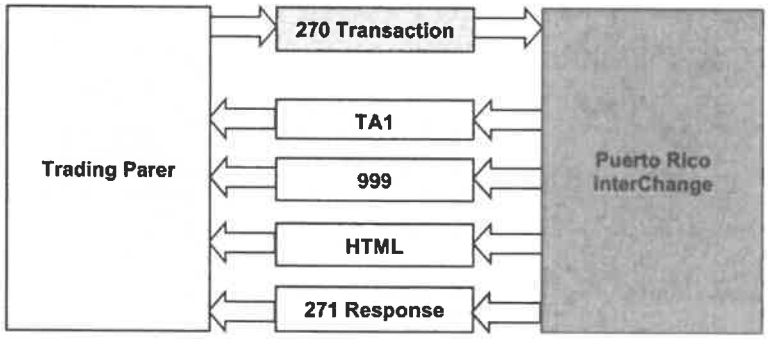
25 - 000 003

Contrato Número

- First-level response — TA1 will be generated when errors occur within the outer envelope (no 999 or 271 will be generated).
- Second-level response — 999 will be generated — "Rejected" 999 (AK901 = R) when errors occur during 270 compliance validation (no 271 will be generated) or "Accepted" 999 (AK901 = A) if no errors are detected during the compliance validation.
- Third-level response — 271 will be generated indicating either the eligibility and benefits **or** AAA errors within request validation.

Each transaction is validated to ensure that the 270 complies with the 005010X279A1 TR3.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error (AK901 = R). Transactions that pass this compliance check will generate an "Accepted" 999 (AK901 = A) file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 (AK901 = P) file back to the sender with an error message indicating the compliance error (all inquiries in the ST/SE envelopes that pass compliance will be processed and a 271 will be generated without the ST/SE loop(s) that failed compliance). Files that have a compliance error will generate a proprietary HTML file that identifies the compliance error in a "human" readable format. Transactions that pass compliance checks, but failed to process (e.g., due to member not being found) will generate a 271 response transaction, including an AAA segment indicating the nature of the error. Transactions that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the requested dates) do not generate AAA segments but will create a 271 using the information in our eligibility and benefit system.



3.2 Transmission Administrative Procedures

This section provides PRMMIS's specific transmission administrative procedures.

The trading partner must determine if the transmission being sent is Test or Production and is using the appropriate indicator. For details about available PRMMIS Access Methods, refer to the Communication Protocol Specifications section.

PRMMIS is available only to authorized users. Submitters must be PRMMIS trading partners. A submitter is authenticated using a username and password assigned by the trading partner.

ADMINISTRACIÓN DE SEGUROS DE SALUD

25-00003

Contrato Número

3.3 Re-transmission Procedure

This section provides PRMMIS's specific procedures for re-transmissions.

The instructions within the 271 AAA data segment provide information on whether resubmission is allowed or what data corrections need to be made in order for a successful response.

In the event of an interrupted communications session, the trading partner only has to reconnect and initiate the file transfer as he or she normally does.

If a file fails compliance, errors must be corrected before re-transmission. Because PRMMIS does not allow duplicate files, before resubmiting a file it is required that a new file name, Interchange Group (ISA), and Transaction Control Numbers be changed.

3.4 Communication Protocol Specifications

This section describes PRMMIS's communication protocol(s).

The communication method currently available to get a member's Eligibility and Benefits from PRMMIS is MoveIT (SFTP) – see "MoveIT/SFTP guide" & "How to use MoveIt Guide" posted on PRMMIS LMS Puerto Rico LMS - Home.

3.5 Passwords

This section describes PRMMIS's use of passwords.

The Portal password must be reset every 60 days. The passwords are maintained by the external user. If a general user needs a password reset, he or she must contact the EDI Helpdesk at (833) 209-8326.

Reminder: Strong security precautions should be taken with passwords. For example, password complexity should be used. Passwords must not be shared or written down where persons other than the authorized party can access them.

4 CONTACT INFORMATION

If the trading partner has questions beyond what is explained in this Companion Guide, refer to the contact information below to reach the appropriate PRMMIS support area.

4.1 Electronic Data Interchange Helpdesk

This section contains detailed information concerning EDI Helpdesk, especially contact numbers.

For questions related to PRMMIS's Eligibility and Benefits Request and Response, contact the EDI Helpdesk at (833) 209-8326.

4.2 Electronic Data Interchange Technical Assistance

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003 12

Contrato Número

Electronic Data Interchange Customer Service can help with connectivity issues or transaction formatting issues at (833) 209-8326 (Monday – Friday, 8:30 a.m. – 4:30 p.m. Central Standard Time (CST).

4.3 Trading Partner ID

The assigned trading partner ID is PRMMIS's key to accessing a provider's trading partner information. Have this number available each time the EDI Helpdesk is contacted.

4.4 Applicable Web Sites

This section contains detailed information about useful Web sites and e-mail addresses.

Additional information is available on the following Web sites:

Accredited Standards Committee (ASC X12) develops and maintains standards for inter-industry electronic interchange of business transactions: *www.x12.org/*.

Accredited Standards Committee (ASC X12N) develops and maintains X12 EDI and XML standards, standards interpretations, and guidelines as they relate to all aspects of insurance and insurance-related business processes: *www.x12.org/*.

American Hospital Association (AHA) Central Office on *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) is a resource for the ICD-9-CM codes used in medical transcription and billing, and for Level I Healthcare Common Procedure Coding System (HCPCS) procedure codes: *www.ahacentraloffice.org/*.

American Medical Association (AMA) is a resource for the *Current Procedural Terminology* (CPT) procedure codes. The AMA copyrights the CPT codes: *www.ama-assn.org/*.

- Centers for Medicare & Medicaid Services (CMS) is the unit within HHS that administers the Medicare and Medicaid programs. The CMS provides the Electronic Health-Care Transactions and Code Sets Model Compliance Plan at *www.cms.hhs.gov/HIPAAGenInfo/*.
- The CMS is the resource for information related to HCPCS procedure codes: *www.cms.hhs.gov/HCPCSReleaseCodeSets/*.
- The CMS is the resource for Medicaid HIPAA information related to the Administrative Simplification provision: *www.cms.gov/medicaid/hipaa/adminsim/*.
- The CORE is a multi-phase initiative of CAQH; CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care: *www.caqh.org/CORE_overview.php/*.
- The CAQH is a nonprofit alliance of health plans and trade associations, working to simplify health care administration through industry collaboration on public-private initiatives. Through two initiatives — the CORE and Universal Provider Datasource (UPD); CAQH aims to reduce administrative burden for providers and health plans: *www.caqh.org/*.
- Designated Standard Maintenance Organizations (DSMO) is a resource for information about the standard-setting organizations and transaction change request system: *www.hipaa-dsmo.org/*.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

Contrato Número

- Healthcare Information and Management Systems (HIMSS) is an organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care: *www.himss.org/*.
- Medicaid HIPAA-Compliant Concept Model (MHCCM) presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit: *www.mhccm.org/*.
- National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to the HHS on health data, statistics, and national health information policy: *www.ncvhs.hhs.gov/*.
- National Council of Prescription Drug Programs (NCPDP) is the standards and codes development organization for pharmacy: *www.ncpdp.org/*.
- National Uniform Billing Committee (NUBC) is affiliated with the AHA and develops standards for institutional claims: *www.nubc.org/*.
- National Uniform Claim Committee (NUCC) is affiliated with the AMA. It develops and maintains a standardized data set for use by the non-institutional health care organizations to transmit claims and encounter information. The NUCC maintains the national provider taxonomy: *www.nucc.org/*.
- Office for Civil Rights (OCR) is the office within the HHS responsible for enforcing the Privacy Rule under HIPAA: *www.hhs.gov/ocr/hipaa/*.
- The federal HHS is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA: *www.aspe.hhs.gov/admnsimp/*.
- Washington Publishing Company (WPC) is a resource for HIPAA-required transaction implementation guides and code sets: *http://www.wpc-edi.com/*.
- Workgroup for Electronic Data Interchange (WEDI) is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA: *www.wedi.org/*.
- The registry for the NPI is the National Plan and Provider Enumeration System (NPPES): *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.
- Other resources pertaining to the NPI: *www.cms.hhs.gov/NationalProvIdentStand/*.
- Implementation guides and non-medical code sets: *store.x12.org/*.
- The HIPAA statute, Final Rules, and related Notices of Proposed Rulemaking (NPRMS): *www.cms.hhs.gov/HIPAAGenInfo/* or *aspe.hhs.gov/datacncl/adminsim.shtml*.
- Information from CMS about ICD-9 and ICD-10 codes: *www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage* or *https://www.cms.gov/ICD10/*.
- Quarterly updates to the HCPCS code set are available from CMS: *www.cms.hhs.gov/HCPCSReleaseCodeSets/*. (CPT-4, or Level 1 HCPCS, is maintained and licensed by the AMA and is available for purchase in various hardcopy and softcopy formats from of variety of vendors.)

ADMINISTRACION DE SEGUROS DE SALUD

25 - 0 0 0 3 14

Contrato Número

- Information at the federal level about Medicaid can be found at *www.cms.hhs.gov/home/medicaid.asp*.
- The CMS online manuals system and Internet-only manuals (IOM) system, including Transmittals and Program Memoranda, at *www.cms.hhs.gov/Manuals/*.
- Place of service codes are listed in the Medicare Claims Processing Manual and are maintained by the CMS at *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf*.

5 CONTROL SEGMENTS / ENVELOPES

5.1 ISA-IEA

This section describes PRMMIS's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

To promote efficient, accurate electronic transaction processing, please note the following PRMMIS specifications:

- The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.
- Each trading partner is assigned a six-digit trading partner ID.
- All dates are in the CCYYMMDD format.
- All dates/times are in the CCYYMMDDHHMM format.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 99 inquiries per Transaction Set (ST-SE).
- Utilize BHT Segment for Transaction Set Inquiry Response association.
- Utilize TRN Segments for Subscriber Inquiry Response association.
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	00	Use "00" to indicate no Authorization Information Present.
C.4		ISA02	Authorization Information		Leave blank
C.4		ISA03	Security Information Qualifier	00	Use "00" to indicate no Security Information Present.
C.4		ISA04	Security Information		Leave blank
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	Enter the value "ZZ
C.5		ISA06	Interchange Sender ID		Enter the six-digit numeric trading partner identification number assigned by PRMMIS interChange.

25 - 00003
15

Contrato Número

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	Enter the value "ZZ'
C.5		ISA08	Interchange Receiver ID		"PRMMIS"
C.5		ISA09	Interchange Date		The date format is YYMMDD.
C.5		ISA10	Interchange Time		The time format is HHMM.
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = Only generate interchange acknowledgment (TA1) if error in envelope.
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is production or test.
			Production Data	P	Enter value "P" to indicate that the file contains production data
			Test Data	T	Enter value "T" to indicate that the file contains test data.
C.6		ISA16	Component Element Separator	:	A colon ":" is recommended.

5.2 GS-GE

This section describes PRMMIS's use of the functional group control segments.

It includes a description of expected application sender and receiver codes.

The table below represents only those fields in which PRMMIS requires a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction — the TR3 should be reviewed for that information.

Note: Puerto Rico only accepts files with one GS/GE loop per file.

GS – Functional Group Header

This section describes the use of the functional group control segments. It includes a description of expected application sender and receiver codes.

The table below shows the fields that PRMMIS will be sending.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.7	None	GS	Functional Group Header		

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.7		GS01	Functional ID Code	HS	Eligibility, Coverage or Benefit Information (270).
C.7		GS02	Application Sender's Code		Carrier's Trading Partner ID
C.7		GS03	Application Receiver's Code		"PRMMIS"
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	"X" Responsible Agency Code
C.8		GS08	Version/ Release/Industry Identifier Code	005010X279A1	Version/ Release/ Industry Identifier Code

GE – Functional Group Trailer

The table below shows the fields that Puerto Rico Medicaid will be sending.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

-

5.3 ST-SE

This section describes PRMMIS's use of transaction set control numbers.

PRMMIS recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with 000000001 and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

ST – Transaction Set Header

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	270	270 Health Care Benefit & Enrollment Maintenance

ADMINISTRACION DE SEGUROS DE SALUD

25 - 000073

Contrato Número

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X279A1	This field contains the same value as GS08.

SE – Transaction Set Trailer

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of segments included in a transaction set including the ST and SE segments
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

5.4 File Delimiters

PRMMIS requests that you use the following delimiters on your 270 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets. Contact the EDI Helpdesk at (833) 209-8326 if there is a need to use a delimiter other than the following.

Data Element
: Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The recommended data element delimiter is an asterisk (*).

Repetition Separator
: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^).

Component-Element
: ISA16 defines the component element delimiter to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:).

Data Segment
: Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended data segment delimiter is a tilde (~).

6 PRMMIS-SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 Terminology

The term "subscriber" will be used as a generic term throughout the Companion Guide.

6.2 Member Limit

File Size is restricted to 5,000 member inquiries per 270 transactions files.

6.3 271 Interpretation Guidelines

The following two types of eligibility and benefit information can be returned in a PRMMIS interChange 271 eligibility response:

- Puerto Rico Medicaid Program eligibility.
- Medicare coverage.

It is important that all aspects of a subscriber's eligibility and benefits are considered when reading an eligibility response. The simple fact that a subscriber is eligible in a health program does not always indicate that the health program should be billed for services rendered. If a subscriber has coverage through private insurance, Medicare, or Medicaid managed care, services should be billed accordingly.

All eligibility and benefit information is accompanied by effective dates. It is important that effective dates are considered in combination with the dates of service (DOS) submitted in the inquiry. If eligibility information is requested for a range of dates, it is possible that the subscriber's coverage may vary at times throughout the range of service dates.

Disclaimer: Information provided in a 271 response is not a guarantee of payment or coverage in any specific amount. Actual benefits depend on various factors, including compliance with applicable administrative protocols, Date Of Service rendered, and benefit plan terms and conditions. It is a provider's responsibility to validate whether or not an authorization is required prior to administering the service to the member.

6.4 Notes on 270 Search Hierarchy

1. If a Medicaid ID (MID) is present, a search is made for a match on the member ID. If no member is found, an error is returned and the 270 should be resubmitted with other criteria.

2. If last name, first name and Social Security number (SSN) are present in the 270, a search of the database is made for the name and SSN match. If no member is found or last name, first name, and SSN are not present;

3. If SSN and DOB are present, a search is made for a match on the SSN and DOB. If no member is found, a AAA segment with a value of 75 (Subscriber not found) in AAA03 is returned.

4. If none of the above information is available to try any of the above searches, a AAA segment with a value of 15 (Required application data missing) in AAA03 is returned.

5. All members are enrolled in either the TXIX or CHIP or CWLTH programs. Members are defined as "subscribers." All requests should be submitted at the subscriber level. Any requests submitted at the dependent level that result in an error (Not Found) will be returned at the dependent level. If the member is a *subscriber* in PRMMIS's membership tables but was submitted in the Dependent loop on the 270 request (2100D), the member will be returned in the Subscriber loop on the 271 response (2100C).

6. If the search for a subscriber is successful, the subscriber's identifying information contained in the 271 response will be taken from the applicable eligibility table. *Note:* The INS segment is not used by PRMMIS.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

19

Contrato Número

7. If the search for a subscriber is unsuccessful, the subscriber's identifying information contained in the incoming 270 will be returned in the 271 response.

6.5 270 Request

No dependent level (Loop 2100D) data should be sent within a 270 Eligibility Inquiry file. All PRMMIS members can be uniquely identified by their subscriber ID number.

If no Date Of Service is sent with the 270 Eligibility Inquiry file, the current date will be used for processing.

PRMMIS does not currently support an explicit service type code (EQ01) other than "30" (Health Benefit Plan Coverage).

PRMMIS interChange does not support 270 requests submitted with multiple EQ segments or repeating of the EQ01 element. If submitted, PRMMIS interChange will process as if EQ01 value of "30" was submitted.

PRMMIS interChange does not support 270 requests submitted with procedure codes or diagnosis pointers (to the HI segment) in the EQ segment. If a procedure code or diagnosis pointer is submitted, PRMMIS interChange will return a 271 response with the "Standard" Service Type (30).

Eligibility requests for a date range will return all plans for the member that are identified by the search criteria submitted. Any plans that had/have coverage during the date range will be returned.

Parameters for requesting past and future eligibility:

- A request can be for any date in the past.
- A date range can be for any 12-month (366-day) period in the past.
- A 271 AAA value of 62 or 63 will be returned if the date range validation fails.

When sending in single date inquiries, if an active plan is not found for the member, a subsequent request with a different date will need to be submitted.

6.6 271 Response

Disclaimer: Information provided in a 271 response is not a guarantee of payment or coverage in any specific amount. Actual benefits depend on various factors, including compliance with applicable administrative protocols, Date Of Service rendered, and benefit plan terms and conditions. It is a provider's responsibility to validate whether or not an authorization is required prior to administering the service to the member.

The 271 response may not be at the same level that was received in the 270 request. All eligibility and benefit responses will be at the subscriber 2100C level.

PRMMIS interChange returns Medicare information, identified by EB01 = "R" (Other or Additional Payor) and EB04 = "MA" or "MB" or "OT". PRMMIS interChange returns the Medicare effective date and the member's Medicare ID.

If the Eligibility check is unsuccessful, PRMMIS interChange will return a 271 response containing a AAA segment noting the reason a match could not be made. If indicated (AAA04 = "C"), correct and resubmit your request.

If the Eligibility check identifies a PRMMIS member who is inactive on the service date requested, PRMMIS will return a 271 response containing EB01 = "6". The 271 response will contain data from the PRMMIS's membership files.

6.7 File Naming Convention

270 Inbound from Carriers

Example:
Submission Date: 06/01/2023
Total Number of members: 9,500 (we recommend limiting each file to 5,000 members)

20230601_ABRV_270_###.dat

Date file was created (**YYYYMMDD format)**
underscore
2 to 4 character abbreviation of Carrier's (MCO/MAO) name
underscore
Type of file – use **270**
underscore
= Sequence number of each file submitted during the day (start with 001 and increment by one)
Use **.dat** or **.txt** for every file

The standards above will avoid accidently overwriting files.
Files submitted with the same name will be rejected as a duplicate.

Example:

20230601_ABRV_270_001.dat	**first 5,000 members**
20230601_ABRV_270_002.dat	**remaining 4,500 members**

271 Outbound to Carriers

SAKID_SAKID_20230601_ABRV_271001.x12

SAKIDs are the Gainwell unique identifiers for this file.

6.8 Scheduled Maintenance

PRMMIS schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. CST.

ADMINISTRACION DE SEGUROS DE SALUD
25 - 00003
Contrato Número 21

7 ACKNOWLEDGEMENTS AND/OR REPORTS

7.1 TA1 — Transaction Acknowledgement

PRMMIS interChange will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced then neither a 999 nor 271 response will be sent. The submitted 270 will need to be corrected and resubmitted.

7.2 999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. PRMMIS interChange will always respond with a 999 for a batch X12 file. If a "rejected" 999 is produced then the 271 response will not be sent. The submitted 270 will need to be corrected and resubmitted.

7.3 Report Inventory

There are no acknowledgement reports at this time.

8 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that PRMMIS has something additional, over and above, the information in the implementation guides. That information can do the following:

1. Limit the repeat of loops or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with PRMMIS.

In addition to the row for each segment, one or more additional rows are used to describe PRMMIS's usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides. The table contains a row for each segment that PRMMIS has something additional, over and above, the information in the TR3s.

8.1 005010X279A1 — 270 Health Care Eligibility Benefit Inquiry

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
63	None	BHT	Beginning of Hierarchical Transaction		
63	None	BHT01	Hierarchical Structure Code	0022	Specify the sequence of hierarchical levels that may appear in the transaction set.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

Contrato Número

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
64	None	BHT02	Transaction Set Purpose Code	13	PRMMIS interChange validates only Code 13 (Request).
64	None	BHT04	Transaction Set Creation Date	CCYYMMDD	Date the transaction was created
69	2100A	NM1	Information Source Name		
69	2100A	NM101	Entity Identifier Code	PR	Enter "PR" to indicate payer.
70	2100A	NM102	Entity Type Qualifier	2	Enter "2" to indicate a non-person entity
70	2100A	NM103	Information Source Last or Organization Name	PRMMIS	Enter "PRMMIS"
71	2100A	NM108	Identification Code Qualifier	PI	Enter "PI" to indicate payer identification.
71	2100A	NM109	Information Source Primary Identifier	PRMP	Enter "PRMP"
75	2100B	NM1	Information Receiver Name		
75	2100B	NM101	Entity Identifier Code	P5	Plan Sponsor
75	2100B	NM102	Entity Type Qualifier	2	Enter "2" to indicate a non-person entity
75	2100B	NM103	Information Source Last or Organization Name		Enter Carrier's Name
77	2100B	NM108	Identification Code Qualifier	SV	Service Provider Number
78	2100B	NM109	Information Receiver Identification Number		Enter the Provider Medicaid ID, 9 chars, leading 0's required
79	2100B	REF	Information Receiver Additional ID		Any data submitted in this segment will not be used in processing the inquiry.
81	2100B	N3	Information Receiver Address		Any data submitted in this segment will not be used in processing the inquiry.
82	2100B	N4	Information Receiver Address		Any data submitted in this segment will not be used in processing the inquiry.
84	2100B	PRV	Information Receiver Provider Information		Any data submitted in this segment will not be used in processing the inquiry.
90	2000C	TRN	Subscriber Trace Number		This segment may be used to assign a trace number to a transaction. 271 responses will contain as many TRN segments as were present on the received 270 inquiry as well as an additional segment originated by the information source.
90	2000C	TRN01	Trace Type Code		Enter 1 = Current Transaction Trace Number

ADMINISTRACIÓN DE SEGUROS DE SALUD

25 - 00003

Contrato Número

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
91	2000C	TRN02	Trace Number		Use this field to assign a unique trace or reference number for this transaction.
91	2000C	TRN03	Trace Assigning Entity Identifier		Use this field for an identification number of the entity that originated the reference identification in TRN02. *Note: The first position must be either a "1" if an EIN is used, a "3" if a DUNS is used or a "9" if a user assigned identifier is used.*
91	2000C	TRN04	Trace Assigning Entity Additional Identifier		Enter your Trading Partner ID with leading zeros
92	2100C	NM1	Subscriber Name		Note: See section 6.6 for rules on search hierarchy.
92	2100C	NM101	Entity Identifier Code	IL	Enter IL = Subscriber
93	2100C	NM102	Entity Type Qualifier	1	Enter 1 = Person
93	2100C	NM103	Subscriber Last Name		Enter the subscriber's last name.
93	2100C	NM104	Subscriber First Name		Enter the subscriber's first name.
95	2100C	NM108	Identification Code Qualifier	MI	MI = Member ID.
96	2100C	NM109	Subscriber Primary Identifier		Enter the subscriber's member ID.
97	2100C	REF	Subscriber Additional Information		Note: See section 6.4 for rules on search hierarchy.
98	2100C	REF01	Reference Identification Qualifier	SY	Enter SY - Social Security number (SSN)
99	2100C	REF02	Subscriber Supplemental Identifier		Enter SSN as qualified by field REF01.
100	2100C	N3	Subscriber Address		Any data submitted in this segment will not be used in processing the inquiry.
101	2100C	N4	Subscriber City, State, ZIP Code		Any data submitted in this segment will not be used in processing the inquiry.
103	2100C	PRV	Provider Information		Any data submitted in this segment will not be used in processing the inquiry.
107	2100C	DMG	Subscriber Demographic Information		The DMG segment should only be used if the subscriber's date of birth (DOB) is to be provided.
108	2100C	DMG01	Date Time Period Format Qualifier	D8	Date Expressed in Format CCYYMMDD
108	2100C	DMG02	Subscriber Birth Date		
110	2100C	INS	Multiple Birth Sequence Number		Any data submitted in this segment will not be used in processing the inquiry.
113	2100C	HI	Subscriber Health Care Diagnosis Code		Any data submitted in this segment will not be used in processing the inquiry.

25 - 0 040 0 3

Contrato Número

IR's Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
122	2100C	DTP	Subscriber Date		The DTP segment can be used to specify a date or range of dates for which eligibility will be verified. If no DTP segment is present, the member's eligibility will be provided for the date the transaction is processed.
123	2100C	DTP01	Date Time Qualifier	291	291 = Eligibility
123	2100C	DTP02	Date Time Period Qualifier	D8 RD8	
			Single Date	D8	
			Range of Dates	RD8	
123	2100C	DTP03	Date Time Period		Enter the date(s) of inquiry for the subscriber's benefits in the format CCYYMMDD or CCYYMMDD-CCYYMMDD.
124	2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
124	2110C	EQ01	Service Type Code	30	PRMP only supports service type code "30" (Health Benefit Plan Coverage).
136	2110C	AMT	Subscriber Spend Down Amount		Any data submitted in this segment will not be used in processing the inquiry.
136	2110C	AMT	Subscriber Spend Down Total Billed Amount		Any data submitted in this segment will not be used in processing the inquiry.
138	2110C	III	Subscriber Eligibility or Benefit Additional Inquiry Information		Any data submitted in this segment will not be used in processing the inquiry.
142	2110C	REF	Subscriber Additional Information		Any data submitted in this segment will not be used in processing the inquiry.
144	2110C	DTP	Subscriber Eligibility / Benefit Date		Any data submitted in this segment will not be used in processing the inquiry.
146	2000D		Dependent Level		Because each subscriber and each of his/her dependents is assigned a unique identification number, dependents are treated as subscribers in the PRMMIS interChange system. Any data submitted at the dependent level will be processed as a subscriber.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

Contrato Número

25

8.2 005010X279A1 — 271 Health Care Eligibility Benefit Response

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
211		BHT	Beginning of Hierarchical Transaction		
211	2000A	BHT01	Hierarchical Structure Code	0022	Specify the sequence of hierarchical levels that may appear in the transaction set.
211	2000A	BHT02	Transaction Set Purpose Code	11	PRMMIS interChange returns Code 11 (Response).
211	2000A	BHT03	Submitter Transaction Identifier		The value in this field will be identical to the unique transaction identifier received in the BHT03 field of the 270 inquiry.
215	2000A	AAA	Request Validation		This segment will be used in the response if the PRMMIS interChange eligibility tables are unavailable at the time of processing.
215	2000A	AAA01	Valid Request Indicator	N Y	
			Indicate that the request or an element in the request is not valid.	N	
			request is valid, however the transaction has been rejected as identified by the code in AAA03.	Y	
215	2000A	AAA03	Reject Reason Code	42	This field will contain "42" to indicate that PRMMIS interChange is unable to respond at the current time.
215	2000A	AAA04	Follow-up Action Code	P	This field will contain a "P" to indicate that the inquiry must be resubmitted.
218	2100A	NM1	Information Source Name		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
221	2100A	PER	Information Source Additional Information		This segment will contain PRMMIS helpdesk information.
226	2100A	AAA	Request Validation		This segment will be returned if an error was detected in the 2100A loop of the 270 inquiry.
226	2100A	AAA03	Reject Reason Code	04 41 42 79	This field will contain "79" to indicate that invalid participant identification has been entered in loop 2100A, field NM109 of the 270 inquiry.
			Authorized Quantity Exceeded	04	Transaction exceeds the number of patient requests allowed.
			Authorization/Access Restrictions	41	Entity identified in GS02 is not authorized to submit 270 transactions.
			Unable to Respond at Current Time	42	Entity identified in either ISA08 or GS03 is unable to process the transaction at the current time.
			Invalid Participant Identification	79	Value in either GS02 or GS03 is invalid.
226	2100A	AAA04	Follow-up Action Code	C	This field will contain "C" to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
232	2100B	NM1	Information Receiver Name		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
236	2100B	REF	Information Receiver Additional Identification		This segment will not be returned.
E-44	2100B	N3	Information Receiver Address		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
E-45	2100B	N4	Information Receiver City, State, ZIP Code		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
238	2100B	AAA	Information Receiver Request Validation		This segment will be returned if there was a problem with the 2100B loop, NM1 receiver name segment of the 270 inquiry.
238	2100B	AAA03	Reject Reason Code	41 43 51 79	
			Authorization/Access Restrictions	41	
			Invalid/Missing Provider Identification	43	
			Provider Not on File	51	
			Invalid Participant Identification	79	
238	2100B	AAA04	Follow-up Action Code	C	This field will contain "C" to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
241	2100B	PRV	Information Receiver Provider Information		This segment will not be returned.
246	2000C	TRN	Subscriber Trace Number		This segment will be used to return the trace number received in the associated subscriber loop of the inquiry (TRN01 = 2).
246	2000C	TRN	Subscriber Trace Number		This segment will be used to assign a unique PRMMIS interChange trace number (TRN01 = 1).
249	2100C	NM1	Subscriber Name		If the member is found the values returned to the receiver in this segment will be from our membership database. If the member is not found the data in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
253	2100C	REF	Subscriber Additional Identification		The member's SSN will be returned if the member was found in the PRMMIS interChange database.
253	2100C	REF01	Reference Identification Qualifier	SY	"SY" = Social Security Number
253	2100C	REF02	Subscriber Supplemental Identifier		This field will contain SSN.
257	2100C	N3	Subscriber Address		This segment will be used to indicate a subscriber's street address. The address will appear as it is contained in the information source's files, regardless of what is sent in the inquiry.
259	2100C	N4	Subscriber City, State, ZIP Code		This segment will be used to indicate a subscriber's additional address information. The information will appear as it is contained in the information source's files, regardless of what is sent in the inquiry.
262	2100C	AAA	Subscriber Request Validation		This segment will be used to report any errors detected in the associated 2100C loop of the inquiry.

ADMINISTRACION DE SEGUROS DE SALUD

25-00003

Contrato Número

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
262	2100C	AAA03	Reject Reason Code	15 42 43 48 51 52 57 58 60 61 62 63 72 73 75 76	
			Required application data missing	15	
			Unable to respond at current time	42	
			Invalid/missing provider identification	43	
			Invalid/missing referring provider identification	48	
			Provider not on file	51	
			Service dates not within provider plan enrollment	52	
			Invalid/missing dates of service	57	
			Invalid date of birth	58	
			Date of birth follows date(s) of service	60	
			Date of death precedes date(s) of service	61	
			Date of service not within allowable inquiry period	62	
			Dates of service not within the same calendar month	63	
			Invalid subscriber ID	72	
			Invalid/missing subscriber name	73	
			Subscriber not found	75	
			Duplicate Subscriber/Insured ID Number	76	
262	2100C	AAA04	Follow-up Action Code	C	This field will contain "C" to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
265	2100C	PRV	Provider Information		This segment will not be returned.
268	2100C	DMG	Subscriber Demographic Information		This segment will be used to indicate a subscriber's DOB. If the member is found the DOB will appear as it is contained in the information source's files. If the member is not found and the DMG segment was in the inquiry this segment will contain the information as it was sent in the inquiry.
271	2100C	INS	Subscriber Relationship		This segment will not be returned.
274	2100C	HI	Subscriber Health Care Diagnosis Code		This segment will not be returned.
283	2100C	DTP	Subscriber Date		This segment will contain the requested eligibility date in the format CCYYMMDD.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
285	2100C	MPI	Subscriber Military Personnel Information		This segment will not be returned.
289	2110C	EB	Subscriber Eligibility or Benefit Information		
291	2110C	EB01	Eligibility or Benefit Information	1 6	PRMMIS interChange returns these codes.
			Active Coverage	1	
			Inactive	6	
292	2110C	EB02	Benefit Coverage Level Code	IND	Health Benefit Plan Coverage
293	2110C	EB03	Service Type Code	30	
298	2110C	EB04	Insurance Type Code	MA MB MC OT	
			Medicare Part A	MA	Indicates Medicare Part A Coverage.
			Medicare Part B	MB	Indicates Medicare Part B Coverage.
			Medicaid	MC	PRMMIS is the coverage being referenced.
			Other	OT	Indicates Medicare Part D (Prescription Drug) Coverage or Other Insurance Coverage.
299	2110C	EB05	Plan Coverage Description		This field will contain the benefit plan name and associated coverage and group codes, separated by pipe delimiter. For example, TXIX|110|MPM
309	2110C	HSD	Health Care Services Delivery		This segment will not be returned.
314	2110C	REF	Subscriber Additional Information		The REF segment will occur at this level of the response in association with Medicare coverage(EB01 = R) to provide the health insurance claim (HIC) number (MBI).
317	2110C	DTP	Subscriber Eligibility/Benefit Date		
317	2110C	DTP01	Date Time Qualifier	307	This field will contain "307" to indicate eligibility.
317	2110C	DTP03	Eligibility or Benefit Date Time Period		This field will contain the date or dates related to the eligibility or benefit information in the 2110C loop.
319	2110C	AAA	Subscriber Request Validation		This segment will not be returned.
322	2110C	MSG	Message Text		Contains the member's municipality code. Format of the message is: "Municipality - 123" where 123 is the code.
324	2110C	III	Subscriber Eligibility or Benefit Additional Information		This segment will not be returned.
328	2110C	LS	Loop Header		This segment will not be returned.
329	2120C	NM1	Subscriber Benefit Related Entity Name		This segment will not be returned.
335	2120C	N3	Subscriber Benefit Related Entity Address		This segment will not be returned.
336	2120C	N4	Subscriber Benefit Related City, State, ZIP Code		This segment will not be returned.
339	2120C	PER	Subscriber Benefit Related Contact Information		This segment will not be returned.
344	2120C	PRV	Subscriber Benefit Related Provider Information		This segment will not be returned.
329	2120C	NM1	Subscriber Benefit Related Entity Name		This segment will not be returned.
346	2120C	LE	Loop Trailer		This segment will not be returned.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

Contrato Número

APPENDICES

1. Implementation Checklist

Contact the EDI Helpdesk at (833) 209-8326 or via e-mail using the Contact link at the bottom of the Portal home page with any questions.

2. Business Scenarios

Terminology

The term "subscriber" will be used as a generic term throughout the Companion Guide. This term could refer to any one of the programs for which the 270/271 Health Care Eligibility/Benefit Inquiry and Information Response (270/271) transaction is being processed:

Member Limit

File Size is restricted to 5,000 member inquiries per 270 transaction file. Up to 99 members can be placed in each ST/SE segment.

271 Interpretation Guidelines

PRMP eligibility and benefit information will be returned in a PRMMIS 5010 standard X12 271 eligibility response transaction.

All eligibility and benefit information is accompanied by effective dates. It is important that effective dates are considered in combination with the dates of service submitted in the inquiry. If eligibility information is requested for a range of dates, it is possible that the subscriber's coverage may vary at times throughout the range of service dates.

270/271 Eligibility, Benefit, or Coverage Inquiry and Response Notes

The EB segment of the 2110C loop in the 271 eligibility response can contain many different types of information relating to the subscriber and can repeat several times. The following grids show the different types of information that can be returned in the EB segment.

PRMMIS Eligibility

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain one of the following values: • "1" — Indicates active coverage. • "6" — Indicates inactive coverage.
2110C	EB02	Coverage Level Code	This field will contain the value "IND" to indicate individual.
2110C	EB03	Service Type Code	If active coverage is indicated in EB01, this field will contain a value of 30
2110C	EB04	Insurance Type Code	This field will contain the value "MC" to indicate that PRMMIS is the coverage being referenced.
2110C	EB05	Plan Coverage Description	This field will contain the benefit plan name, concatenated with coverage code and group code For example, TXIX|110|MPM.

Medicare

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain the value "R" to indicate other or additional payer.
2110C	EB02	Coverage Level Code	This field will contain the value "IND" to indicate individual.

ADMINISTRACION DE SEGUROS DE SALUD

25-3000003

Contrato Número

2110C	EB03	Service Type Code	This field will not be populated as PRMMIS is not the true information source.
2110C	EB04	Insurance Type Code	This field will contain one of the following values: • "MA" — Indicates that Medicare Part A is the coverage being referenced. • "MB" — Indicates that Medicare Part B is the coverage being referenced. • "OT" — Indicates Medicare Part D (Prescription Drug) coverage.

ADMINISTRACION DE
SEGUROS DE SALUD

25 - 00003

Contrato Número

3. Transmission Examples – one file containing multiple members/examples. Each query is bounded by STSE with the specifics enclosed in a box. Orange highlights the first statement of the query. Yellow highlights errors.

INBOUND 270	OUTBOUND 271	
ISA*00* *00* *ZZ*B000001 *ZZ*PRMMIS *230131*0800*^*00501*222222222*0*T*:~	ISA*00* *00* *ZZ*PRMMIS *ZZ*B000001 *230816*1518*^*00501*200000015*0*T*:~	
GS*HB*B000001*PRMMIS*20230710*0800*338*X*005010X279A1~	GS*HB*PRMMIS*B000001*20230816*151858*200000015*X*005010X279A1~	
ST*270*0001*005010X279A1~	ST*271*0001*005010X279A1~	
BHT*0022*13*108*20230710*0800~	BHT*0022*11*108*20230816*1518~	
HL*1**20*1~	HL*1**20*1~	
NM1*PR*2*MID*****PI*PRMP~	NM1*PR*2*MID*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*2*1*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*3*2*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*2322800100*PRMMIS ~	added by 271 process
NM1*IL*1******MI*12313115545~	TRN*2*123456789*8391128616*690150~	
DTP*291*RD8*20230501-20230509~	NM1*IL*1*LUZ|COLON*BURGOS*M***MI*12313115545~	last name | last name 2
EQ*30~	N3*HC 2 BOX 13970~	postal address line 1 only
SE*12*0001~	N4*GURABO*PR*007789617~	
	DMG*D8*19500416*F~	birth date, sex
	DTP*291*RD8*20230501-20230509~	dates of service
	EB*1*IND*30*MC*Title 19 TXIX|130|NAM~	Medicaid benefit plan
	DTP*307*RD8*20230501-20240430~	Medicaid elig dates
	MSG*Municipality - 132~	new
	EB*R*IND**MA~	Medicare Part A
	REF*F6*9G05AP1HK57~	MBI
	DTP*307*RD8*20011201-22991231~	Medicare Part A elig dates
	EB*R*IND**MB~	Medicare Part B
	REF*F6*9G05AP1HK57~	MBI
	DTP*307*RD8*20020301-22991231~	Medicare Part B elig dates

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

Contrato Número

	EB*R*IND**OT~	Medicare Part D
	REF*F6*9G05AP1HK57~	MBI
	DTP*307*RD8*20211201-22991231~	Medicare Part D elig dates

ST*270*0002*005010X279A1~
BHT*0022*13*108*20230705*0800~

HL*1**20*1~	HL*4**20*1~	
NM1*PR*2*NAME-SSN*****PI*PRMP~	NM1*PR*2*NAME-SSN*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*5*4*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*6*5*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*2322800101*PRMMIS ~	added by 271 process
NM1*IL*1*BHARAJ*ALEXZAVIER~	TRN*2*123456789*8391128616*690150~	
REF*SY*637138718~	NM1*IL*1*BHARAJ*ALEXZAVIER~	
DTP*291*RD8*20230401-20230409~	REF*SY*637138718~	
EQ*30~	AAA*N**58*C~	member not found
SE*13*0002~	DTP*291*RD8*20230401-20230409~	
	HL*7**20*1~	

ST*270*0003*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*7**20*1~	
NM1*PR*2*NAME-DOB*****PI*PRMP~	NM1*PR*2*NAME-DOB*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*8*7*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*9*8*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000C8*PRMMIS ~	
NM1*IL*1*BHARAJ*ALEXZAVIER~	TRN*2*123456789*8391128616*690150~	
DMG*D8*19571007~	NM1*IL*1*BHARAJ*ALEXZAVIER****MI*55779235742~	last name only, no last name 2
DTP*291*RD8*20230501-20230509~	N3*1979 27 CALLE 25 DE JULIO APT 4 APT 3~	
EQ*30~	N4*MAUNABO*PR*007077465~	
SE*13*0003~	DMG*D8*19571007*F~	
	DTP*291*RD8*20230501-20230509~	

	EB*6*IND*30*MC~	no Medicaid eligibility
	DTP*307*RD8*20230501-20230509~	dates of service

ST*270*0004*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*10**20*1~	
NM1*PR*2*SSN-DOB*****PI*PRMP~	NM1*PR*2*SSN-DOB*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*11*10*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*12*11*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000C9*PRMMIS ~	
NM1*IL*1*ADDED*SEGMENT~	TRN*2*123456789*8391128616*690150~	
REF*SY*637138718~	NM1*IL*1*ADDED*SEGMENT~	required segment
DMG*D8*19571007~	REF*SY*637138718~	
DTP*291*RD8*20230501-20230509~	AAA*N**75*C~	no match found
EQ*30~	DMG*D8*19571007~	
SE*14*0004~	DTP*291*RD8*20230501-20230509~	dates of service

ST*270*0005*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*13**20*1~	
NM1*PR*2*AFTER DEATH*****PI*PRMP~	NM1*PR*2*AFTER DEATH*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*14*13*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*15*14*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CB*PRMMIS ~	
NM1*IL*1******MI*91103729271~	TRN*2*123456789*8391128616*690150~	
DTP*291*RD8*20230601-20230603~	NM1*IL*1******MI*91103729271~	
EQ*30~	AAA*N**61*C~	date of death before dates of service
SE*12*0005~	DTP*291*RD8*20230601-20230603~	dates of service

ST*270*0006*005010X279A1~
BHT*0022*13*108*20230710*0800~

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

Contrato Número

HL*1**20*1~	HL*16**20*1~	
NM1*PR*2*BEFORE BIRTH*****PI*PRMP~	NM1*PR*2*BEFORE BIRTH*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*17*16*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*18*17*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CC*PRMMIS ~	
NM1*IL*1******MI*91170268899~	TRN*2*123456789*8391128616*690150~	
DTP*291*RD8*20230503-20230504~	NM1*IL*1******MI*91170268899~	
EQ*30~	AAA*N**60*C~	birth date after dates of service
SE*12*0006~	DTP*291*RD8*20230503-20230504~	dates of service

ST*270*0007*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*19**20*1~	
NM1*PR*2*DUP-INACTIVE*****PI*PRMP~	NM1*PR*2*DUP-INACTIVE*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*20*19*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*21*20*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CD*PRMMIS ~	
NM1*IL*1******MI*13001766552~	TRN*2*123456789*8391128616*690150~	
DMG*D8*20031003~	NM1*IL*1*FRANQUI|DERECK*RIVERA****MI*12302564264~	
DTP*291*RD8*20230501-20230509~	N3*PO BOX 320~	
EQ*30~	N4*TOA BAJA*PR*009510320~	
SE*13*0007~	DMG*D8*19980903*M~	
	DTP*291*RD8*20230501-20230509~	
	EB*6*IND*30*MC~	not eligible for Medicaid
	DTP*307*RD8*20230501-20230509~	
	EB*R*IND**MA~	Medicare Part A
	REF*F6*4DD5RR5MU75~	
	DTP*307*RD8*20171101-22991231~	
	EB*R*IND**MB~	Medicare Part B
	REF*F6*4DD5RR5MU75~	
	DTP*307*RD8*20191101-22991231~	

ADMINISTRACION DE
SEGUROS DE SALUD

25 - 00003

Contrato Número

ST*270*0008*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*22**20*1~	
NM1*PR*2*DUP-NAME-DOB*****PI*PRMP~	NM1*PR*2*DUP-NAME-DOB*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*23*22*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*24*23*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CF*PRMMIS ~	
NM1*IL*1*BURGOS*LIZ~	TRN*2*123456789*8391128616*690150~	
DMG*D8*19500416~	NM1*IL*1*BURGOS*LIZ~	
DTP*291*RD8*20230501-20230509~	AAA*N**75*C~	no match found
EQ*30~	DMG*D8*19500416~	
SE*13*0008~	DTP*291*RD8*20230501-20230509~	

ST*270*0009*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*25**20*1~	
NM1*PR*2*INELIGIBLE*****PI*PRMP~	NM1*PR*2*INELIGIBLE*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*26*25*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*27*26*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CG*PRMMIS ~	
NM1*IL*1******MI*55779235742~	TRN*2*123456789*8391128616*690150~	
DTP*291*RD8*20230501-20230509~	NM1*IL*1*BHARAJ*ALEXZAVIER****MI*55779235742~	
EQ*30~	N3*1979 27 CALLE 25 DE JULIO APT 4 APT 3~	
SE*12*0009~	N4*MAUNABO*PR*007077465~	
	DMG*D8*19571007*F~	
	DTP*291*RD8*20230501-20230509~	
	EB*6*IND*30*MC~	not eligible for Medicaid
	DTP*307*RD8*20230501-20230509~	

ST*270*0010*005010X279A1~
BHT*0022*13*108*20230710*0800~

ADMINISTRACION DE
SEGUROS DE SALUD

25 - 00003

Contrato Número

HL*1**20*1~	HL*31**20*1~	
NM1*PR*2*FUTURE DATE*****PI*PRMP~	NM1*PR*2*FUTURE DATE*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*32*31*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*33*32*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*232280010B*PRMMIS ~	
NM1*IL*1******MI*12313115545~	TRN*2*123456789*8391128616*690150~	
DTP*291*D8*20230901~	NM1*IL*1*LUZ|COLON*BURGOS*M***MI*12313115545~	
EQ*30~	N3*HC 2 BOX 13970~	
SE*12*0010~	N4*GURABO*PR*007789617~	
	DMG*D8*19500416*F~	
	DTP*291*RD8*20230901-20230901~	
	EB*1*IND*30*MC*Title 19 TXIX|130|NAM~	
	DTP*307*RD8*20230501-20240430~	
	MSG*Municipality - 132~	
	EB*R*IND**MA~	
	REF*F6*9G05AP1HK57~	
	DTP*307*RD8*20011201-22991231~	
	EB*R*IND**MB~	
	REF*F6*9G05AP1HK57~	

	SE*154*0001~
GE*10*338~	GE*1*200000015~
IEA*1*222222222~	IEA*1*200000015~

4. Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to PRMMIS and its providers.

Q: What are the main differences between a 271 and a 999?
A: 271 is the response to a 270 and contains eligibility information. 999 is an acknowledgement transaction that indicates if a 270 file was accepted or rejected. 999 does not contain any eligibility information.

Q: Is there a limit to the number of inquiries I can submit at once?
A: We recommend you follow HIPAA requirements for a maximum of 5,000 inquiries per file. Also, only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Q: What information is returned on the 271?
A: All available information about the member will be returned. This may include:

- Member address.
- Member ID, SSN, and/or other agency ID.
- PRMMIS Medicaid benefit plan.
- Medicare Part A, B, D if available.

Q: Will I get back different information if I check by member ID vs. name?
A: The information sent is specific to the member and the complete details are sent, regardless of inquiry by member ID or name.

Q: Are any fields case sensitive?
A: PRMMIS accepts the extended character set. Uppercase characters are recommended.

Q: When can we send 270s and expect to receive 271s?
A: The run schedule for the 270/271 cycle is twice a day, at noon AST and after the 834 cycle is complete, expected to be around 10pm AST. Files will be immediately processed and results available for pickup the same day.

Q: What are the parameters for requesting past and future eligibility?
A:

- Any date in past allowed
- Any date in future allowed
- From Date of Service must be less than To Date of Service (otherwise error 57)
- To and From Date of Service must be in the same month (otherwise error 62)

5. Change Summary

Version 1.3 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Modified by Gainwell

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	18	GS08	Version/ Release/Industry Identifier Code		Corrected value
			FAQs		Dates of service
	21		File naming standard		Change to 20230601_ABRV_270_001.dat
2110C	29	MSG	Municipality Code		Contains the member's municipality code. Format of the message is: "Municipality - 123" where 123 is the code.
	19		6.4 Notes on 270 Search Hierarchy		If no member is found, an error is returned and the 270 should be resubmitted with other criteria.
	32		Transmission Example		Updated with FUTURE DATE example and all successful queries show "Municipality"

Version 1.2 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Modified by Gainwell

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	16	ISA08			Comments/Notes changed to: "PRMMIS"
	17	GSA02			Comments/Notes changed to : Carrier's Trading Partner ID
	17	GSA03			Comments/Notes changed to: "PRMMIS"
	33		Transmission Example		Minor change HS to HB
	33		Transmission Example		Minor change EB*I* to EB*1*
	39		FAQs		Added run cycle information
2000C	23	TRN TRN01			Corrected Loop to be 2000C

	17	GS01		HS	Corrected value Eligibility, Coverage or Benefit Information (270).

Version 1.1 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Modified by Gainwell

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	21		File Naming Convention		Added 271 outbound file name example
2100B	23	NM108	Identification Code Qualifier	SV	Changed to this code
2100B	23	NM109	Provider Medicaid ID		Changed to this value
2100C	27-28	AAA03	Reject Reason Code	76	Added this code. "Duplicate Subscriber/Insured ID Number"
2000C	23	TRN04	Trace Assigning Entity Additional Identifier		Added this Reference.
	30	Business Scenarios	Member Limit		Added this sentence: Up to 99 members can be placed in each ST/SE segment.
	31		Transmission Examples		Added example 270 and 271 X12

Version 1.0 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Approved: 06/2023
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	ALL PAGES				270/271 transaction is new to Puerto Rico's PRMMIS.

ADMINISTRACION DE SEGUROS DE SALUD

25 - 00003

Contrato Número