ASC X12
The Accredited Standards Committee

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The National Health Plan ID is accommodated in all of the ASC X12 transactions mandated under HIPAA. Focusing on 005010, since that is the version that will be mandated when the National Health Plan ID is implemented, at a summary level, the National Health Plan ID occurs thirty times. Additionally, it is referenced in situational rules or segment and data element notes another nineteen times.

These instances all occur within the actual transaction themselves, and does not account for any use by willing trading partners of a National Health Plan ID within the transaction envelopes as the mutually agreed upon sender or receiver ID (as applicable). If willing trading partners mutually agree to use the National Plan ID in the enveloping structures, it would function solely as a trading partner ID which is used to route the transactions.

Instances of the National Health Plan ID in the transactions that are an inquiry and response pair, appear in the sender and receiver entity loops to identify a payer when the payer is one of the two entities. The data sent in these specific data elements are often used for sorting or routing purposes, whether by clearinghouses moving provider transactions to a payer or sometimes by the receiving payer to route to internal work queues. The most frequent numbers used today are NAIC numbers, EIN, BCBS Plan Code, and Proprietary Numbers.

There are a few specific instances that we wish to highlight that are important for the industry to evaluate how current implementations use the data. If the National Health Plan ID is defined differently than is currently used, the impact to payers, providers, and vendors, both clearinghouses and software, will be significant.

In the eligibility response transaction (271), both the Subscriber Benefit Related Entity (Loop 2120C) and the Dependent Benefit Related Entity (Loop 2120D) require the use of the National Health Plan ID when the benefit related entity is a payer. This would occur when the benefit related entity is a different payer than that identified as the Information Source or when the Information Source is an entity other than a payer.

In the claim transactions, the Claim Filing Indicator (SBR09) is no longer allowed once the National Health Plan ID is mandated. The Claim Filing Indicator breaks down to levels such as Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), and Medicare Part B. This data element is used quite extensively today in front end edit routines as well as claims logic within processing systems. If Payers do not enumerate at the level to which they expect the claim filing indicator data, and enumerate at a less granular level, it will impact not only payer implementations and processing logic, but also provider and vendor (clearinghouse or software) implementations as well. The inability to use the claim filing indicator also occurs when reporting other insurance for the policyholder, which impacts coordination of benefits claims as well.

Refer to pages two through seven for additional information on the X12 usage.

X12 Health Plan ID

XV = Centers for Medicare and Medicaid Services PlanID

Plan ID Numbers in use today – NAIC numbers, EIN, BCBS Plan Code, Proprietary Numbers

Analysis based on 005010 TR3s

X12 278/278 (X217)

2010A NM1 Utilization Management Organization (Request and Response)

Identify Utilization Management Organization (UMO) when the UMO is the payer

XV - Required on or after the mandated HIPAA National Plan ID implementation date when the UMO is the payer. Use PI (Payor Identification) until the National Plan ID is mandated if the UMO is a payer.

2010B NM1 Requester Name (Request and Response)

Requester Name when the Requester is the payer

XV - No Code value notes

2010EB Additional Information Patient Contact Name

Identify when destination is other than the UMO and that destination is a payer

XV - Use if the destination is a payer.

2010FB Additional Service Information Contact Name

Identify when destination is other than the UMO and that destination is a payer

XV - Use if the destination is a payer.

X12 820 (X218)

1000A Premium Receiver's Name

XV - This is Required for a HIPAA compliant implementation when the National PlanID is mandated. Until that time, code FI is the alternate HIPAA compliant identifier.

BPR Financial Information

Payer Identifier

Reference Payer ID by data element name, no situational rules requiring National Plan ID when mandated

X12 834 (X220)

1000B Payer

Payer Identification

XV - No Code value notes

1000C TPA/Broker Name

TPA/Broker Identifier

XV - No Code value notes

2330 Coordination of Benefits Related Entity

Coordination of Benefits Insurer Identification when known by the Sponsor

XV - No Code value notes

X12 835 (X221)

1000A Payer Identification

Required when the National PlanID is mandated for use. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

XV - Required if the National PlanID is mandated for use.

1000B Payee Identification

XV - This is REQUIRED when the National Health Plan Identifier is mandated for use and the payee is a health plan. This only applies in cases of post payment recovery.

2100 Crossover Carrier Name

Coordination of Benefits Carrier Identifier

XV - Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.

2100 Corrected Priority Payer Name

Required when a Payer determines another Payer has priority to process a claim and the Payer is not transferring the claim to the Priority Payer.

XV - Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.

BPR Financial Information

Payer Identifier

Reference Payer ID by data element name, no situational rules requiring National Plan ID when mandated

TRN Reassociation Trace Number

Payer Identifier

This must be a 1 followed by the payer's EIN (or TIN).

1000A Additional Payer Identification

Reference Payer ID by qualifier value, situational rule = For Medicare carriers or intermediaries, use this qualifier for the Medicare carrier or intermediary ID number. For Blue Cross and Blue Shield Plans, use this qualifier for the Blue Cross Blue Shield association plan code.

X12 837D, 837I, and 837P (X224, X223, X222)

2010AC Pay-To Plan Name

Pay-To Plan Primary Identifier for willing partner subrogation payment requests

XV – On or after the mandated implementation date for the HIPAA National Plan Identifier (National Plan ID), XV must be sent. Prior to the mandated implementation date and prior to any phase-in period identified by Federal regulation, PI must be sent. If a phase-in period is designated, PI must be sent unless:

1. Both the sender and receiver agree to use the National Plan ID,

2. The receiver has a National Plan ID, and

3. The sender has the capability to send the National Plan ID.

If all of the above conditions are true, XV must be sent. In this case the Payer Identification Number that would have been sent using qualifier PI can be sent in the corresponding REF segment using qualifier 2U.

2010BB Payer Name

Destination Payer Identifier

XV – On or after the mandated implementation date for the HIPAA National Plan Identifier (National Plan ID), XV must be sent. Prior to the mandated implementation date and prior to any phase-in period identified by Federal regulation, PI must be sent. If a phase-in period is designated, PI must be sent unless:

1. Both the sender and receiver agree to use the National Plan ID,

2. The receiver has a National Plan ID, and

3. The sender has the capability to send the National Plan ID.

If all of the above conditions are true, XV must be sent. In this case the Payer Identification Number that would have been sent using qualifier PI can be sent in the corresponding REF segment using qualifier 2U.

2330B Other Payer Name

Coordination of Benefit Other Payer Primary Identifier

XV – On or after the mandated implementation date for the HIPAA National Plan Identifier (National Plan ID), XV must be sent. Prior to the mandated implementation date and prior to any phase-in period identified by Federal regulation, PI must be sent. If a phase-in period is designated, PI must be sent unless:

1. Both the sender and receiver agree to use the National Plan ID,

2. The receiver has a National Plan ID, and

3. The sender has the capability to send the National Plan ID.

If all of the above conditions are true, XV must be sent. In this case the Payer Identification Number that would have been sent using qualifier PI can be sent in the corresponding REF segment using qualifier 2U.

2010AC Pay-To Plan Secondary Identification

Required prior to the mandated implementation date for the HIPAA National Plan Identifier when an additional identification number to that provided in the NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.

2000B Subscriber Information

Claim Filing Indicator

Required prior to mandated use of the HIPAA National Plan ID. If not required by this implementation guide, do not send.

2010BB Payer Secondary Identification

Required prior to the mandated implementation date for the HIPAA National Plan Identifier when an additional identification number to that provided in the NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.

2320 Other Subscriber Information

Claim Filing Indicator for prior payer claim

Required prior to mandated use of the HIPAA National Plan ID. If not required by this implementation guide, do not send.

2330B Other Payer Secondary Identification

Required prior to the mandated implementation date for the HIPAA National Plan Identifier when an additional identification number to that provided in the NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.

SBR09 – Claim Filing Indicator Code

Required prior to mandated use of the HIPAA National Plan ID. If not required by this implementation guide, do not send.

Valid Values:

11 = Other Non-Federal Programs

12 = Preferred Provider Organization (PPO)

13 = Point of Service (POS)

14 = Exclusive Provider Organization (EPO)

15 = Indemnity Insurance

16 = Health Maintenance Organization (HMO) Medicare Risk

17 = Dental Maintenance Organization

AM = Automobile Medical

BL = Blue Cross/Blue Shield

CH = Champus

CI = Commercial Insurance Co.

DS = Disability

FI = Federal Employees Program

HM = Health Maintenance Organization

LM = Liability Medical

MA = Medicare Part A

MB = Medicare Part B

MC = Medicaid

OF = Other Federal Program (Use code OF when submitting Medicare Part D claims.

TV = Title V

VA = Veterans Affairs Plan

WC = Workers' Compensation Health Claim

ZZ = Mutually Defined (Use Code ZZ when Type of Insurance is not known.)

X12 270/271 (X279)

2100A Information Source Name (270)

Eligibility/Benefit Information Source, e.g. payer, HMO, employer

XV - Use code value "XV" if the Information Source is a Payer and the National PlanID is mandated for use. Otherwise one of the other codes may be used.

2100B Information Receiver Name (270)

Eligibility/Benefit Information Receiver, e.g. provider or employer)

XV - If the information receiver is a payer and the CMS National PlanID is mandated for use, code value "XV" must be used, otherwise, use code value "PI".

2100A Information Source Name (271)

Eligibility/Benefit Information Source, e.g. payer, HMO, employer

XV - Use code value "XV" if the Information Source is a Payer and the National PlanID is mandated for use. Otherwise one of the other codes may be used.

2100B Information Receiver Name (271)

Eligibility/Benefit Information Receiver, e.g. provider or employer)

XV - If the information receiver is a payer and the CMS National PlanID is mandated for use, code value "XV" must be used, otherwise, use code value "PI".

2120C Subscriber Benefit Related Entity (271)

Identifies an entity associated with the eligibility or benefits being identified in the 2110C loop such as a provider (e.g. primary care provider), an individual, an organization, another payer, or another information source;

XV - If the entity being identified is a payer and the CMS National PlanID is mandated for use, code value "XV" must be used, otherwise, one of the other codes may be used.

2120D Dependent Benefit Related Entity (271)

Identifies an entity associated with the eligibility or benefits being identified in the 2110C loop such as a provider (e.g. primary care provider), an individual, an organization, another payer, or another information source;

XV - If the entity being identified is a payer and the CMS National PlanID is mandated for use, code value "XV" must be used, otherwise, one of the other codes may be used.

X12 276/277 (X212)

2100A Payer Name (276/277)

Payer Identifier

XV - Required when the National Payer Identification is mandated for use.