Centers for Medicare & Medicaid Services (CMS)

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Baltimore, MD 21244-1850

<Medicaid Organization>

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

DRA Companion Guide
to the
HIPAA ASC X12N Version 004010X092/A1 Implementation Guide
and
ASC X12 Version 005010X279 Technical Report Type 3

DRA Companion Guide Version 1.0

June 2010

Preface

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

[This Medicaid DRA Companion Guide is provided by the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, to assist State Medicaid agencies and payers in implementing the Payer Initiated Eligibility/Benefit (PIE) Transaction. Since the goal of this transaction is to simplify implementation for payers who must submit transactions to multiple Medicaid agencies, Medicaid agencies should expect to receive this transaction as described in this Guide, and may disregard any content that is not needed.

This DRA Companion Guide is written to support both American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 004010X092/A1 and ASC X12 005010X279 Implementation Guides. In Section 9, Transaction Specific Information, there is an area for the Medicaid agency to discuss its current status or plans to support these two standards. As an alternative, the agency may remove the references to the unsupported standard throughout the DRA Companion Guide.

Within this Guide are headers and blocks of standard language that should be used as-is by Medicaid agencies. There are other items of text that may have to be adapted by individual agencies; and fields that will be tagged as input items. CMS has adopted different fonts for each of these types of text as follows:

Boilerplate text appears in black Arial font.

<text> *indicates a field that is tagged as an input item and should be replaced with information specific to the particular Medicaid agency.*

Instructions to the author appear as blue italicized text enclosed in square brackets (i.e., [text]), and should be deleted from the final document that goes to the payers.]

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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 **<Medicaid agency>** 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 Medicaid agencies. Agreement regarding geographic areas to be covered by the transaction and the schedule and frequency of transaction delivery should be addressed in the trading partner agreement.

1.2 OVERVIEW

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

- ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Response Implementation Guide Version 004010X092/A1 (hereafter referred to as Version 4010)
- 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 Medicaid agencies 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, **<Medicaid agency>** 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 X12N 270/271 Health Care Eligibility/Benefit Inquiry and Response Implementation Guide Version 004010X092/A1 (Version 4010)
- ASC X12 270/271 Health Care Eligibility/Benefit Inquiry and Response Technical Report Type 3 Version 005010X279 (Version 5010)

1.4 ADDITIONAL INFORMATION

[The Medicaid agency may add any additional information that is unique to their environment here. If no additional information is required this section can be removed.]

2 GETTING STARTED

2.1 WORKING WITH <MEDICAID AGENCY>

Please use the following contact information to coordinate the process of establishing a working relationship with **<Medicaid agency>**:

[Provide the full contact information for the project manager in charge of implementing solutions to comply with the DRA. Include name, address, title, phone number, email address, and fax number.]

2.2 TRADING PARTNER REGISTRATION

Please use the following contact information to coordinate all trading partner registration and trading partner agreements for **<Medicaid agency>**:

[Provide the full contact information for the individual in your organization who is empowered to sign trading partner agreements. Medicaid agency may wish to attach their trading partner agreement.]

3 TESTING WITH THE PAYER

<Medicaid agency> 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 following contact information to coordinate testing with **<Medicaid agency>**:

[Provide the full contact information for the project manager or system developer/tester in charge of testing with payers.]

4 CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

Payers should contact the individuals 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 following contact information should be used for issues that arise.

5.1 EDI CUSTOMER SERVICE

[Provide contact information for the help desk support for payers regarding questions about structure of the transmission.]

5.2 EDI TECHNICAL ASSISTANCE

[Provide contact information for the technical support for payers regarding questions about the connectivity and security of transmissions.]

5.3 APPLICABLE WEBSITES / EMAIL

[Provide URL and email contact information for any other information that may be helpful to payers —e.g., on-line registration, current contact information.]

6 CONTROL SEGMENTS / ENVELOPES

The PIE Transaction conforms to ASC X12 Control Segments / Envelopes (ISA-IEA, GS-GE, and ST-SE) for Version 4010 and Version 5010. Since files will be transmitted infrequently, files sizes will be large and will contain more than the usual number of records. The preferred file size and number of records will be identified in the trading partner agreement and may change depending on the communications protocol. 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 the trading partner agreement.

7 ACKNOWLEDGEMENTS AND/OR REPORTS

A single positive ASC X12 acknowledgement will be sent indicating that the transmission was received. For Version 4010, a functional acknowledgement (997) will be sent; for Version 5010, an implementation acknowledgement (999) will be sent. Negative acknowledgements will not be sent. If a positive acknowledgement is not received, resend the file once only. If a positive acknowledgement is still not received, contact the **<Medicaid agency>** EDI Customer Service. Acknowledgements for individual subscriber records within the PIE Transaction will not be sent. **<Medicaid agency>** will not reply indicating which subscribers matched the **<Medicaid agency>** database.

8 TRADING PARTNER AGREEMENTS

The sharing of information received from the payers is limited to use by the **<Medicaid agency>** and its vendors 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

<Medicaid agency> requires a Subscriber Date or Dependent Date (DTP segment) in the Subscriber Name loop (2100C) and Dependent Name loop (2100D) to identify the range of dates covered by the eligibility information search. **<Medicaid agency>** will use these elements to determine whether the PIE Transaction is a full replacement or an incremental update to previous PIE Transactions.

<Medicaid agency> 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). To allow payers to specify coverage, specific EB segment data elements are not supported in this DRA Companion Guide. **<Medicaid agency>** 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 **<Medicaid agency>** 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 **<Medicaid agency>** 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:

1. The payer requires the component in order to correctly process eligibility inquiries (270s) or claims (837s).

2. **<Medicaid agency>** requires the component in order to support matching to the **<Medicaid agency>** 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 are allowed.

[Here the Medicaid Agency should describe the status of their implementation of Version 4010 vs. Version 5010 unless all references to the unsupported standard have been removed. Examples of implementation status text are:

This guidance is designed to accommodate both Version 4010 and Version 5010 standards. At this time <Medicaid agency> supports Version 4010 only. Support for Version 5010 is scheduled to begin in Month, Year.

At this time <Medicaid agency> supports both Version 4010 and 5010. Support for Version 4010 is scheduled to be discontinued Month, Year.

At this time <Medicaid agency> 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 **<Medicaid agency>** and the payer mutually agree to any adjustments.

TABLE 1 – PIE TRANSACTION SPECIFIC INFORMATION

Page # 4010	Page # 5010	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	249	2100C	NM1	Subscriber Name			Required
194	250	2100C	NM103	Subscriber Last Name		1/35	Required
194	250	2100C	NM104	Subscriber First Name		1/25	Required
194	250	2100C	NM105	Subscriber Middle Name or Initial		1/25	Required when available.
195	251	2100C	NM108	Identification Code Qualifier	MI	1/2	Required

Page # 4010	Page # 5010	Loop ID	Reference	Name	Codes	Length	Notes/Comments
195	251	2100C	NM109	Identification Code		2/80	Required. Send Member Identification Number or unique identifier required by the payer on claims submissions.
196	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.
197	254	2100C	REF01	Reference Identification Qualifier		2/3	
				Social Security Number	SY		Required. Send the “SY” Social Security Number in the first REF segment.
198	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”.
200	257	2100C	N3	Subscriber Address			Required when available.
200	257	2100C	N301	Subscriber Address Line		1/55	Required when available.
200	258	2100C	N302	Subscriber Address Line		1/55	Required when the second address line exists.
201	259	2100C	N4	Subscriber City, State, Zip Code			Required when available.
201	260	2100C	N401	Subscriber City Name		2/30	Required when available.

Page # 4010	Page # 5010	Loop ID	Reference	Name	Codes	Length	Notes/Comments
202	260	2100C	N402	Subscriber State Code		2/2	Required when available.
202	260	2100C	N403	Subscriber Postal Zone or ZIP Code		3/15	Required when available.
210	268	2100C	DMG	Subscriber Demographic Information			Required
211	269	2100C	DMG02	Subscriber Birth Date		1/35	Required
211	269	2100C	DMG03	Subscriber Gender Code	F,M,U	1/1	Required
216	284	2100C	DTP	Subscriber Date			Required. Send the Date Time Period that reflects the total time period covered by the PIE Transaction.
216	284	2100C	DTP01	Date Time Qualifier	307	3/3	Required
217	284	2100C	DTP02	Date Time Period Format Qualifier	RD8	2/3	Required
217	284	2100C	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 subscriber was only covered during the last year.
219	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).
233	309	2110C	HSD	Health Care Services Delivery			Required when needed to fully define the eligibility or benefit represented by the preceding EB segment.

Page # 4010	Page # 5010	Loop ID	Reference	Name	Codes	Length	Notes/Comments
238	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.
240	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.
240	317	2110C	DTP01	Date Time Qualifier	307	3/3	Required
241	318	2110C	DTP02	Date Time Period Format Qualifier	RD8	2/3	Required
241	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.
250	329	2120C		Subscriber Benefit Related Entity			Required when a subscriber's benefit-related entity information (such as another information source) is available, e.g. a pharmacy benefit manager contracted by the information source.
254	335	2120C	N3	Subscriber Benefit Related Entity Address			Required when available.
255	336	2120C	N4	Subscriber Benefit Related Entity City, State, Zip Code			Required when available.

Page # 4010	Page # 5010	Loop ID	Reference	Name	Codes	Length	Notes/Comments
265	347	2000D	HL	Dependent Level			Refer to the 4010 and 5010 Implementation Guides for usage of the dependent loop.
271	354	2100D	NM1	Dependent Name			Required
272	355	2100D	NM103	Dependent Last Name		1/35	Required
272	355	2100D	NM104	Dependent First Name		1/25	Required
272	355	2100D	NM105	Dependent Middle Name		1/25	Required when available.
274	357	2100D	REF	Dependent Additional Information			Required. Send 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.
275	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.
276	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”.
277	361	2100D	N3	Dependent Address			Required when available.
277	361	2100D	N301	Dependent Address Line		1/55	Required when available.

Page # 4010	Page # 5010	Loop ID	Reference	Name	Codes	Length	Notes/Comments
277	362	2100D	N302	Dependent Address Line		1/55	Required when the second address line exists.
278	364	2100D	N4	Dependent City, State, Zip Code			Required when available.
278	364	2100D	N401	Dependent City Name		2/30	Required when available.
279	364	2100D	N402	Dependent State Code		2/2	Required when available.
279	364	2100D	N403	Dependent Postal Zone or ZIP Code		3/15	Required when available.
287	372	2100D	DMG	Dependent Demographic Information			Required
288	373	2100D	DMG02	Dependent Birth Date		1/35	Required
288	373	2100D	DMG03	Dependent Gender Code	F, M, U	1/1	Required
289	375	2100D	INS	Dependent Relationship			Required when available.
290	376	2100D	INS01	Insured Indicator	N	1/1	Required
290	376	2100D	INS02	Individual Relationship Code		2/2	Required
292	377	2100D	INS17	Birth Sequence Number		1/9	Required when available.
293	388	2100D	DTP	Dependent Date			Required. Send the Date Time Period that reflects the total time period covered by the PIE Transaction.
293	388	2100D	DTP01	Date Time Qualifier	307	3/3	Required
294	388	2100D	DTP02	Date Time Period Format Qualifier	RD8	2/3	Required

Page # 4010	Page # 5010	Loop ID	Reference	Name	Codes	Length	Notes/Comments
294	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.
295	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).
310	413	2110D	HSD	Health Care Services Delivery			Required when needed to fully define the eligibility or benefit represented by the preceding EB segment.
315	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.
317	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.
317	421	2110D	DTP01	Date Time Qualifier	307	3/3	Required
318	421	2110D	DTP02	Date Time Period Format Qualifier	RD8	2/3	Required

Page # 4010	Page # 5010	Loop ID	Reference	Name	Codes	Length	Notes/Comments
318	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.
327	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.
331	438	2120D	N3	Dependent Benefit Related Entity Address			Required when available.
332	439	2120D	N4	Dependent Benefit Related Entity City, State, Zip Code			Required when available.

Appendix A Implementation Checklist

[This section may be deleted, or the Medicaid agency may add instructions here. This may include trading partner agreement set-up, steps to establish connectivity, and testing.]

Appendix B Business Scenarios

The PIE Transaction will be submitted to **<Medicaid agency>** on a predetermined schedule and frequency using the transmission mechanism and schedule and including subscribers (and dependents) residing in the appropriate geographic areas as agreed upon in the trading partner agreement. 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.hhs.gov/ThirdPartyLiability/DRA/CompanionGuideBusinessScenarios

Appendix C Change Summary

[The Medicaid agency will indicate key changes to the document. A sample matrix is provided and may be modified to effectively communicate changes to the payers.]

TABLE 2 – CHANGE SUMMARY

Version	Date	Organization/Point of Contact	Description of Changes
1.0	**<mm/dd/yy>**	**<Medicaid agency>** *Office*	Initial Version
1.1	**<mm/dd/yy>**	**<Medicaid agency>** *Office*	*Updated Contact Information.*

Appendix D Glossary and Acronyms

TABLE 3 – GLOSSARY

Term	Definition
Information Receiver	In the case of the PIE Transaction, the information receiver is **<Medicaid agency>**.
Information Source	In the case of the PIE Transaction, the information source is also referred to as the payer.
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.

Acronym	Definition
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	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	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.