# 15.   5010 834 STANDARD COMPANION GUIDE

## A.   Transaction Introduction

Standard Companion Guide (CG) Transaction Information

Effective January 1, 2023

IEHP Instructions related to Implementation Guides (IG) based

On X12 Version 005010X220A1
Benefit Enrollment and Maintenance (834)

Companion Guide Version Number: 2.0
2023

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## A.  Transaction Introduction

### PREFACE

This transaction instruction is expected to be used in parallel with the Technical Report Type 3 (TR3) implementation guides (IG) available for purchase from X12 at https://x12.org.. It is provided because Inland Empire Health Plan wants to clarify the IG instructions for submission of specific electronic transactions. This companion guide is not meant to exceed the requirements or usages of data nor replace the guidelines expressed in the TR3s.

### CONTACT INFORMATION

For further questions regarding Eligibility 834 Files, please contact:

### EDI edispecialist@iehp.org or 909-890-2025 BACKGROUND

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. 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 HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

**Compliance according to HIPAA**
The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s).
- Change the meaning or intent of the standard's implementation specification(s).

**Compliance according to ASC X12**
ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

### INTENDED USE

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirement documents. This companion guide conforms to all the

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requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statement.

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## B.   Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

**ISA Segment - Interchange Control Header**

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---------|-----------|------|-------|----------------|
| ISA | | Interchange Control Header | | |
| | ISA05 | Interchange ID Qualifier | ZZ | Mutually Defines |
| | ISA06 | Interchange Sender ID | 00303 | '00303'- IEHP |
| | ISA07 | Interchange ID Qualifier | ZZ | Mutually Defines |
| | ISA08 | Interchange Receiver ID | Receiver Code | IEHP assigned submitter code. |
| GS | | Functional Group Header | | |
| | GS02 | Application Sender's Code | 00303 | Same Value as ISA06 |
| | GS03 | Application Receiver's Code | Receiver Code | Same Value as ISA08 |
| BGN | | Beginning Segment | | |
| | BGN01 | Transaction Set Purpose | 00 | Original submission |
| | BGN08 | Action Code | 2 | Change (update) used for daily files. |
| | | | RX | Replace used for monthly files. |
| 1000A | N1 | Sponsor  Name | | |
| | N101 | Entity Identifier Code | P5 | Plan Sponsor |
| | N102 | Name | "Inland Empire Health Plan" | "Inland Empire Health Plan" |
| | N103 | Identifier Code Qualifier | FI | Federal Taxpayer's Identification Number |
| 1000B | N1 | Payer Name | | |
| | N101 | Entity Qualifier Code | IN | Insurer |
| | N102 | Name | | Receiver Name. |
| | N103 | Identification Code Qualifier | FI | Federal Taxpayer's Identification Number |
| 2000 | INS | Member Level Detail | | |
| | INS03 | Maintenance Type Code | 030 | Full File (Monthly) |
| | | | 001 | Change Files (Daily) |
| | INS06 | Medicare Status Code | A | Part A |
| | | | B | Part B |

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## B.  Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | C | Part A & B |
| | | | E | No Medicare |
| | INS08 | Employment Status Code | AC | Active Status |
| | | | TE | Terminated or Hold Status |
| 2000 | REF | Subscriber Identifier | | |
| | REF01 | Reference Identification Qualifier | 0F | Subscriber Number |
| | REF02 | Reference Identification | | IEHP 14-digit ID |
| 2000 | REF | Member Policy Number | | |
| | REF01 | Reference Identification Qualifier | 1L | Member Group Number |
| | REF02 | Reference Identification | | Group Code. *Note: The Group Code in this segment is valid only for the most current active enrollment span. For historical Group Codes, see the appropriate HD04-05 segment.* |
| | | | RVC-MED | Medi-Cal |
| | | | SBC-MED | Medi-Cal |
| | | | RVC-MMD | Medi-Cal |
| | | | SBC-MMD | Medi-Cal |
| | | | RVC-CMC | IEHP DualChoice Cal MediConnect |
| | | | SBC-CMC | IEHP DualChoice Cal MediConnect |
| | | | RVC-DSNP | Medi-Cal DSNP |
| | | | SBC-DSNP | Medi-Cal DSNP |
| | | | RVC-H8894001 | Medicare DSNP |
| | | | SBC-H8894001 | Medicare DSNP |
| | | | OTH-H8894001 | Medicare DSNP |
| 2000 | REF | Member Supplemental Identifier | | |
| | REF01 | Reference Identification Qualifier | F6 | MBI (Only Reported with Medicare Members) |

### B. Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---------|-----------|------|-------|----------------|
| | | | 17 | CIN |
| | | | ZZ | HCP and HCP Status for the member's active enrollments, (up to five plans reported for each of the current month and the first prior month, to promote coordination of care – data separated by semi-colon) If the codes in REF01 **correspond to multiple FAME data elements in REF02, the values for each data** element will be concatenated in the defined order, and delimited with a semi-colon ";". *See Table B-1 for HCP Status list* *Note: An HCP Status of 05 or 59 indicates that DSNP Member is in a "deeming period" status* |
| 2000 | DTP | Member Level Dates | | |
| | DTP01 | Date Time Period Qualifier | 474 | Medicaid End Date (Redetermination Date) |
| 2100A | NM1 | Member Name | | |
| | NM108 | Identification Code Qualifier | ZZ | Medicare Beneficiary Identifier (MBI) |
| 2100A | DMG | Member Demographics | | |
| | DMG05-3 | Industry Code | | If DMG05-2 is populated, the RET codes correspond as follows to the CDC Ethnic codes. |
| | | | 2106-3 | 1 – White |
| | | | 2135-2 | 2 – Hispanic |
| | | | 2054-5 | 3 – Black |
| | | | 2028-9 | 4 – Asian or Pacific Islander |

## B. Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | 1002-5 | 5 – Alaskan Native or American Indian |
| | | | 2036-2 | 7 – Filipino |
| | | | 2034-7 | C – Chinese |
| | | | 2033-9 | H – Cambodian |
| | | | 2039-6 | J – Japanese |
| | | | 2040-4 | K – Korean |
| | | | 2080-0 | M – Samoan |
| | | | 2029-7 | N – Asian Indian |
| | | | 2076-8 | P - Hawaiian |
| | | | 2087-5 | R – Guamanian |
| | | | 2041-2 | T – Laotian |
| | | | 2047-9 | V – Vietnamese |
| | | | 2131-1 | Z – Other |
| 2100A | LUI | Member Language | | |
| | LUI01 | Identification Code Qualifier | LE | ISO 639 Language Codes Used |
| | LUI02 | Identification Code | SPA | 1 - Spanish |
| | | | JPN | 3 – Japanese |
| | | | KOR | 4 – Korean |
| | | | TGL | 5 – Tagalog |
| | | | CHI | C – Other Chinese Languages |
| | | | ARM | E – Armenian |
| | | | LAO | I – Lao |
| | | | TUR | J – Turkish |
| | | | HEB | K – Hebrew |
| | | | FRE | L – French |
| | | | POL | M – Polish |
| | | | RUS | N – Russian |
| | | | POR | P – Portuguese |
| | | | ITA | Q – Italian |
| | | | ARA | R – Arabic |
| | | | SMO | S – Samoan |

### B. Included ASC X12 Implementation Guides - 005010X220A1 Benefit Enrollment and Maintenance (834)

| Loop ID | | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|---|
| | | | | THA | T – Thai |
| | | | | VIE | V – Vietnamese |
| | | | | UND | Null or Blank |
| | | LUI04 | Use of Language Indicator | 6 | Language Written |
| | | | | 7 | Language Spoken |

| 2300 | HD | | Health Coverage | | |
|---|---|---|---|---|---|
| | HD01 | | Maintenance Type Code | 001 | Change |
| | | | | 002 | Delete |
| | | | | 021 | Addition |
| | | | | 024 | Cancellation or Termination |
| | | | | 025 | Reinstatement |
| | | | | 030 | Audit or Compare |
| | HD03 | | Insurance Line Code | HLT | HLT Health |
| | HD04 | | Plan Coverage Description | BID;IPA;HCP Code;HCP Status;Group Code | HD04 is a composite field made up of BID, IPA, HCP Code, HCP Status and Group Code separated by a ';' *Note: See Loop 2000-REF='1L' for list of Group Codes* |
| | HD04-01 | | | BID | Beneficiary ID |
| | HD04-02 | | | IPA | Delegated Risk Group |
| | HD04-03 | | | HCP Code | 305 – Riverside 306 – San Bernardino |
| | HD04-04 | | | HCP Status | *See Table B-1. Note: An HCP Status of 05 or 59 indicates that DSNP Member is in a "deeming" status* |

## B.   Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

| | HD04-05 | | Group Code | *See Loop 2000-REF='1L' for list of Group Codes* |
|---|---|---|---|---|
| | HD05 | Coverage Level Code | IND | 'IND'- Individual |
| 2300 | DTP | Health Coverage Dates | | |
| | DTP01 | Date/Time Qualifier | 348 | Benefit Begin |
| | | | 349 | Benefit End |
| 2300 | REF | Health Coverage Policy Number | | |
| | REF01 | Reference Identification Qualifier | 17 9V CE RB | The following qualifiers are used to reference the FAME data indicated in REF02: |

| | | | | '17' - Client Reporting Category<br>'9V' - Payment Category<br>'CE' - Class of Contract Code<br>'RB' - Rate Code Number |
|---|---|---|---|---|
| | REF02 | Reference Identification | OHC; CBAS-IND 1st digit; CBAS-IND 2nd digit; CCI Opt Out Indicator; ESRD Indicator; Part D LIS Reassigned Indicator; CCI Exclusion Indicator; Nursing Facility Resident; SI-NSI indicator; HCBS HIGH indicator; INSTITUTIONAL indicator; SUBPLAN indicator; | When REF01 = '17' (12 sub-elements separated by semi-colon) |
| | REF02-01 | OHC | A | Pay and Chase (Applies to any carrier) |
| | | | C | Military Benefits Comprehensive |
| | | | D | Medicare Part D Prescription Drug Coverage |
| | | | E | Vision Plans |
| | | | F | Medicare Part C Health Plan |
| | | | G | Medical parolee |
| | | | H | Multiple Plans comprehensive |
| | | | I | Institutionalized |
| | | | K | Kaiser |

| | | | | |
|---|---|---|---|---|
| | | | L | Dental-only policies |
| | | | P | PPO/PHP/HMO/EPO not otherwise specified |
| | | | Q | Commercial pharmacy plans |
| | | | V | Any carrier other than above (includes multiple coverage) |
| | | | W | Multiple plans non-comprehensive |
| | | | N or blank | Not Applicable |
| | REF02-02 | CBAS-IND 1$^{st}$ Digit | 1 | CBAS Enrollment – Class 1 7/1/11 – 2/29/12 (eligible for ECM) |
| | | | 2 | ECM Enrollment – Class 1 7/1/11 – 2/29/12 (not eligible for CBAS) |
| | | | 3 | CBAS Enrollment – Class 2 3/1/12 – 8/30/2014 (never eligible for ECM) |
| | | | 4 | Unbundled – Class 1 |
| | | | 5 | Unbundled – Class 2 |
| | | | 9 | No longer enrolled in CBAS or ECM |

### B. Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

| | REF02-03 | CBAS-IND 2nd Digit (Medi-Cal Indicator Participation) | A | Full Dual in Managed Care |
|---|---|---|---|---|
| | | | B | Full Dual in Fee-for-Service |
| | | | C | Partial Dual in Managed Care |
| | | | D | Partial Dual in Fee-For-Service |
| | | | E | SPD in Managed Care |
| | | | F | SPD in fee-For Service |
| | | | G | Managed Care (Not Dual or SPD) |
| | | | H | Fee-For-Service (Not Dual or SPD) |
| | REF02-04 | CCI Opt Out Indicator | Y | Beneficiary opted out of Cal MediConnect and will not be included in future passive enrollments |
| | | | *Null* | Beneficiary has not opted out of Cal MediConnect |
| | REF02-05 | ESRD (End Stage Renal Disease) Indicator | Y | Beneficiary has diagnosis of ESRD within the specified timeframe and is excluded from Cal Medi-Connect (800-series) HCP, except in San Mateo and Orange counties, but is included in MLTSS |
| | | | N | Beneficiary has a diagnosis of ESRD outside the specified timeframe and is not excluded from Cal Medi-Connect |
| | | | *Null* | Beneficiary has no diagnosis of ESRD |
| | REF02-06 | Part D LIS Reassigned Indicator | Y | Beneficiary is an LIS reassignee and excluded from passive enrollment |

### B. Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

| | | | Null | Beneficiary is not a Part D LIS reassignee |
|---|---|---|---|---|
| | REF02-07 | CCI Exclusion Indicator; | M | Beneficiary is in a Multipurpose Senior Services Program (MSSP), and is eligible for enrollment in Cal Medi-Connect and MLTSS. |
| | | | N | Beneficiary is in MSSP and is a Veterans' Home resident – Not eligible for a Cal MediConnect or MLTSS enrollment |
| | | | O | Beneficiary is in a 1915(c) waiver- Not eligible for Cal MediConnect enrollment but is eligible for MLTSS. |
| | | | P | Beneficiary is in a 1915(c) waiver and a Veterans' Home resident - Not eligible for Cal MediConnect enrollment or MLTSS enrollment. |
| | | | V | Beneficiary is a Veterans'Home residient – Not eligible for Cal MediConnect or MLTSS enrollment. |
| | | | D | Beneficiary is in a Developmentally disabled waiver – Not available for Cal MediConnect enrollment, but is eligible for MLTSS |

| | | | I | Beneficiary is in an ICF DD and not available for a Cal MediConnect or MLTSS enrollment. |
| --- | --- | --- | --- | --- |
| | | | *Null* | no data available |
| | REF02-08 | Nursing Facility Resident; | Y | Beneficiary is a resident of a nursing facility |
| | | | *Null* | No information exists that indicates whether the beneficiary is a resident of a nursing facility or not |
| | REF02-09 | SI-NSI Indicator; | S | SI Identifies IHSS beneficiary as Severely Impaired |
| | | | N | NSI Identifies IHSS beneficiary as Non-Severely Impaired |
| | REF02-10 | HCBS HIGH Indicator; | Y N | If 'Y', Plan is reporting to DHCS that beneficiary is receiving CBAS and/or MSSP services |
| | REF02-11 | INSTITUTIONAL Indicator; | Y N | If 'Y', beneficiary has been identified as being in a Long Term Care facility |
| | REF02-12 | SUBPLAN Indicator; Identifies beneficiaries enrolled in a subcontracted health plan | BC | Anthem Blue Cross Partnership |
| | | | CF | Care1st Partner Plan, LLC |
| | | | CH | Community Health Plan |
| | | | HN | Health Net Comm Solutions |
| | | | KA | Kaiser Permanente Cal, LLC |
| | | | LA | LA Care Health Plan |
| | | | MO | Molina Healthcare Partner |
| | | | *Null* | No Subplan |

### B.  Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

|  | REF02 | Reference Identification | Medicare Part A Status Code; Medicare Part B Status Code; Medicare Part D Status Code | When REF01 = '9V' (3 sub-elements separated by semi-colon) |
|---|---|---|---|---|
|  | REF02 | Reference Identification | (All the Aid Codes and Eligibility Status Codes) Primary AID-Code; Primary ESC; SPEC1-AID; SPEC1-ESC; SPEC2-AID; SPEC2-ESC; SPEC3-AID; SPEC3-ESC | When REF01 = 'CE' (8 sub-elements separated by semi-colon) |
|  | REF02 | Reference Identification | Capitated Aid Code | When REF01 = 'RB' |
| 2310 | NM1 | Provider Name |  |  |
|  | NM101 | Entity Identifier Code | P3 | Primary Care Provider |
|  |  |  | Y2 | Manage Care Organization |
|  |  |  | 80 | Hospital |
|  | NM109 | Identification Code |  | Use NPI only for Providers Identification. Use NPI for Hospitals also. |

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## B.    Included ASC X12 Implementation Guides - 005010X220A1 Benefit Enrollment and Maintenance (834)

| Loop 2320 - Coordination of Benefits | | | | |
|---|---|---|---|---|
| 2320 | COB01 | Payer Responsibility Sequence Number | P | Primary |
| | | | S | Secondary |
| | | | T | Tertiary |
| | | | U | Unknown |
| | COB02 | Policy Number | | Member's Policy Number |
| | COB03 | Coordination of Benefits Code | 1 | Coordination of Benefits |
| | COB04 | Service Type Code | 1 | Medical Care |
| 2320 | REF01 | Reference Identification Qualifier | 6P | Group Number |
| | REF02 | Member Group or Policy Number | | |
| 2320 | DTP01 | COB Benefit Date | 344 | COB Benefits Begin |
| | | | 345 | COB Benefits End |
| | DTP02 | Date Format Qualifier | D8 | Date expressed in CCYYMMDD |
| | DTP03 | Date | | COB Date |
| Loop 2330 – Coordination of Benefits Related Entity | | | | |
| 2330 | NM101 | Entity Identifier Code | IN | Insurer |
| | NM103 | Organization Name | | COB Insurer Name |
| 2330 | N3 | Address Information | | |
| | N4 | City, State, Zip Code | | |
| 2330 | PER01 | | CN | General Contact |
| | PER03 | Communication Qualifier | TE | Telephone |
| | PER04 | Communication Number | | |

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## B. Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

| Loop 2750 – Reporting Category – TRR Type | | | | |
|---|---|---|---|---|
| 2750 | LX01 | Assigned Number | | |
| 2750 | N101 | Entity Identifier Code | 75 | Participant |
| | N102 | Member Reporting Category Name | TRR TYPE | |
| 2750 | REF01 | Reference Identification Qualifier | 17 | Client Reporting Category |
| | REF02 | Reference Identification | HOSPICE TRANSPLANT ESRD DIALYSIS | |
| 2750 | DTP01 | Time Qualifier | 007 | Set to: 007 - Effective |
| | DTP02 | Format Qualifier | D8 RD8 | |
| | DTP03 | Date Time Period | | Effective date or span for reporting category |

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### B.  Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

| Loop 2750 – Reporting Category – Alternate Format Selection | | | | |
|---|---|---|---|---|
| 2750 | LX01 | Assigned Number | | |
| 2750 | N101 | Entity Identifier Code | 75 | Participant |
| | N102 | Member Reporting Category Name | Alternative Format Selection | |
| 2750 | REF01 | Reference Identification Qualifier | 17 | Client Reporting Category |
| | REF02 | Reference Identification | 1 | Audio CD |
| | | | 2 | Braille |
| | | | 3 | Electronic |
| | | | 4 | Large Print |
| | | | 5 | Text to ASL |
| | | | 6 | Audio CD – English |
| | | | 7 | Braille – English |
| | | | 8 | Electronic – English |
| | | | 9 | Large Print – English |
| | | | 10 | Text to ASL – English |
| | | | 11 | Audio CD – Spanish |
| | | | 12 | Braille – Spanish |
| | | | 13 | Electronic – Spanish |
| | | | 14 | Large Print – Spanish |
| | | | 15 | Audio CD – Chinese |
| | | | 16 | Electronic – Chinese |
| | | | 17 | Large Print - Chinese |
| | | | 18 | Audio CD – Vietnamese |
| | | | 19 | Electronic – Vietnamese |
| | | | 20 | Large Print - Vietnamese |
| 2750 | DTP01 | Time Qualifier | 007 | Set to: 007 - Effective |
| | DTP02 | Format Qualifier | D8 RD8 | |
| | DTP03 | Date Time Period | | Effective date or span for reporting category |

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### B. Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

| Loop 2750 – Reporting Category – CMS Race | | | | |
|---|---|---|---|---|
| 2750 | LX01 | Assigned Number | | |
| 2750 | N101 | Entity Identifier Code | 75 | Participant |
| | N102 | | Race | CMS Race |
| 2750 | REF01 | Reference Identification Qualifier | 17 | Client Reporting Category |
| | REF02 | Reference Identification | 0 | Unknown |
| | | | 1 | White |
| | | | 2 | Black |
| | | | 3 | Other |
| | | | 4 | Asian |
| | | | 5 | Hispanic |
| | | | 6 | North American Native |

| Loop 2750 – Reporting Category – Member Out of Pocket Indicator | | | | |
|---|---|---|---|---|
| 2750 | LX01 | Assigned Number | | |
| 2750 | N101 | Entity Identifier Code | 75 | Participant |
| | N102 | Member Reporting Category Name | MOOP | Member Out of Pocket Indicator |
| 2750 | REF01 | Reference Identification Qualifier | 17 | Client Reporting Category |
| | REF02 | Reference Identification | Yes | MOOP Met |
| 2750 | DTP01 | Time Qualifier | 007 | Set to: 007 - Effective |
| | DTP02 | Format Qualifier | D8 | |
| | DTP03 | Date Time Period | | Effective date MOOP is met |

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## B. Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

**Table B-1:** **HCP Status Codes**

| HCP Status | Description |
|---|---|
| 00 | Voluntary Disenrollment. No capitation paid. |
| 01 | Active Enrollment. Capitation paid. |
| 05*** | HCP hold due to recipient Medi-Cal ineligibility. No capitation paid. |
| 09 | Mandatory Disenrollment. No capitation paid. |
| 10 | Voluntary Disenrollment. Capitation recovery required. |
| 15 | Incarceration: Active recoupment |
| 19 | Mandatory Disenrollment. Capitation recovery required. |
| 40 | Voluntary Disenrollment occurred before enrollment became effective. |
| 41 | Hold Due to Loss of Medi-Cal Eligibility. |
| 49 | Mandatory Disenrollment occurred before enrollment became effective. |
| 51 | Enrollment Activated from HCP Hold or Unmet SOC. Supplemental Capitation to be paid end of month. |
| 55 | Potential plan member. Unmet SOC. |
| 59*** | HCP hold due to HCP coverage limits. No capitation paid. |
| 61 | Hold due to Loss of State-Specific Eligibility for Cal MediConnect. |
| P4 | Pending Enrollment. Application accepted. |
| S0 | Voluntary disenrollment. Capitation recovery processed. |
| S1 | Active enrollment - Supplemental capitation paid |
| S5 | Incarceration: Retroactive recoupment of capitation |
| S9 | Mandatory Disenrollment. Capitation recovery processed. |
| B1 | Active Enrollment. Newborn Capitation paid under Mother for 2 months. |

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### B. Included ASC X12 Implementation Guides – 005010X220A1 Benefit Enrollment and Maintenance (834)

\*\*\* Deeming Status:   When a Medi-Cal beneficiary fails to timely provide their county with redetermination information they are placed into a hold status for 90 days, entering their Medi-Cal deeming period. While in the deeming period, a beneficiary that is enrolled with IEHP

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DualChoice (DSNP HMO), is able to access Medi-Cal services through fee-for-service (FFS) Medi-Cal rather than IEHP while continuing to access Medicare services through IEHP. If during this 90-day period the members regains their Medi-Cal status, they will be reinstated/reactivated with IEHP. Their active Medi-Cal with IEHP will remove them from the Loss of SNP status. If they do not return their redetermination packet or are determined ineligible after 90 days, the member will be terminated from IEHP DualChoice.

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## C.   Control Segment and Envelopes

# ** Note**
**_Please use One ST and SE transaction set per File_**

The below table represent only those field that IEHP requires a specific value in or has guidance as to what that 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.

| Reference | Name | Codes | Notes/Comments |
|---|---|---|---|
| | Interchange Control Header | | |
| ISA01 | Authorization Information Qualifier | "00" | |
| ISA02 | Authorization Information | Space Fill | |
| ISA03 | Security Information Qualifier | "00" | |
| ISA04 | Security Information | Space Fill | |
| ISA05 | Interchange ID Qualifier (Sender) | "ZZ" | |
| ISA06 | Interchange Sender ID | "00303" | IEHP's Receiver ID |
| ISA07 | Interchange ID Qualifier (Receiver) | "ZZ" | |
| ISA08 | Interchange Receiver ID | | Assigned by IEHP |
| ISA11 | Repetition Separator | "^" | Preferred |
| ISA14 | Acknowledgment Requested | "1" | TA1 (997). |
| ISA15 | Interchange Usage Indicator | "P" | "T" is used during testing phase. All other transactions use "P" |
| ISA16 | Component Element Separator | ":" | Preferred |
| | GS- Functional Group Header Segment | | |
| GS01 | Functional Identifier Code | "BE" | Health Care Claim |
| GS02 | Application Sender's Code | | Assigned by IEHP. Same as ISA06. |
| GS03 | Application Receiver's Code | | Assigned by IEHP |
| GS08 | Version/Release/Industry Identifier Code | "005010X220A1" | "005010X220A1" = 834 |
| ST | Transaction Set Header | | |
| ST03 | Implementation Convention Reference | "005010X220A1" | "005010X220A1" = 834 |

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## D.   Business Scenarios

**Example 1- Full Eligibility Enrollment File**

All active Members will be provided in the full eligibility enrollment file at the beginning of each month. This file includes new Members, Members continuing coverage from the prior month and enrollment terminations.

**Example 2- Daily Update Files**

The daily eligibility enrollment file only contains updates, terminations, and additions to Member enrollments. Updates include demographic, group, and PCP changes.

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## E.      Frequently Asked Questions

**Q. How is a monthly vs. daily eligibility file identified?**

**A.** There are currently two ways for a month vs. daily file to be identified, through the naming convention and within the file. The file naming convention includes a M for monthly and a D for daily. In addition, the maintenance type code reported in the 2000 INS 03 '030' is reported for monthly, and '001' is reported for daily files.

**Q. What is the file naming convention for 834 benefit and enrollment files?**

Naming Conventions

The naming convention for 834 benefit and enrollment consists of the following:
- All file name starts with a M (monthly) or D (daily)
- The second character is the three-character submitter ID provided by IEHP.
- The 5th through 12<sup>th</sup> character is the date the file was created - YYYYMMDD.
- The 13th character is the file two-digit sequence identifier sent on the same day beginning with 01.
- The extension will be 834

EDI 834 File Example - File Sent from IEHP to IPA

An example of the file naming convention for the first submission of an 834 benefit and enrollment File is:   M00X2014060101.834
- M Indicates a monthly file
- 00X identifies the IPA
- 2014 is year the file was created
- 06 is month the file was created
- 01 is day the file was created
- 01 is first sequence sent on same day (01-10)
- .834 HIPAA 834 file extension

**Q. Where do I find information on connectivity protocol and file transfer procedures?**

**A.**   Please refer to the EDI manual published at https://ww3.iehp.org/en/providers/provider-manuals  for information regarding the above areas. The information published in this companion guide is meant to be used in conjunction with the implementation guides from Washington Publishing Company for detailed instructions on the line level and IEHP's EDI Manual for connectivity and processing procedures.

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## E. Frequently Asked Questions

**Q.** If there is not an Aid Code in the Member Record, is it okay to process that Member Record?

**A.** Yes, an Aid Code is not required for the CMC Line of Business in the outbound IEHP 834 file; this will result in IEHP not including the REF*CE segment in the outbound IEHP 834 file.

Please note that it is possible that the State can report these Members as 'reinstates', which will result in Members' Aid Codes being included in the subsequent outbound IEHP 834 file.

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## F.    Other Resources

 **https://ww3.iehp.org/en/providers/provider-manuals**

- IEHP's website where the EDI manual and other resources are located.

- **https://x12.org**

  X12Implementation guides (TR3) can be purchased from this site.

- **http://www.wedi.org/**

  Workgroup for Electronic Data Interchange in Healthcare.