

Version 8

Utah State Dept. of Health
Division of Medicaid and Health Financing

834 COMPANION GUIDE

Utah Specific Transaction Instructions

834 Benefit Enrollment and Maintenance
ASCX12N 834 (005010X220)

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 834 Version 5010 implementation guide has been established as the standard of compliance. Utah Medicaid will implement the Addenda corrections for Benefit Enrollment and Maintenance (005010X220). The implementation guide is available electronically at www.wpc-edi.com. The following supplemental requirements are specific to Utah Medicaid and are intended to serve as a companion guide to the HIPAA ANSI X12N implementation guide.

Requirements:

1. An Electronic Commerce Agreement must be in place. The form is available at www.UHIN.org
2. A Utah Medicaid EDI Enrollment application must be completed and on file prior to Medicaid generating an 834 Benefit Enrollment and Maintenance. The form is available at http://health.utah.gov/hipaa/medicaid_pcn.htm

Page	Data Element	Values / Comments
35	Action Code	"2" – Update "4" – Synchronize file
36	Master Policy Number	Contract number
39	Plan Sponsor Name	"Medicaid and Health Financing"

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Page	Data Element	Values / Comments
49	Maintenance Type Code	"001" – Change "021" – Addition "024" – Termination "025" – Reinstate "030" – Sync File
54	Insured Individual Death Date	
55	Subscriber Number	"0F" – Subscriber Number
56	Subscriber ID	Medicaid "PACMIS" ID
57	Member Supplemental Identifier	3H – Case Number
58	Member Supplemental Number	Case Number
63	Subscriber Last Name	
63	Subscriber First Name	
63	Subscriber Middle Name	
64	ID Code Qualifier	"34" – SSN
64	Subscriber Identifier	Social Security Number of client.
66	Communication Number Qualifier	"TE" – Telephone
66	Communication Number	Client Phone Number
68	Subscriber Address Line	Residential Address (line 1)
68	Subscriber Address Line	Residential Address (line 2, if needed)
69	Subscriber City Name	Residential Address
69	Subscriber State Code	Residential Address
70	Subscriber ZIP Code	Residential Address

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Page	Data Element	Values / Comments
70	Location Qualifier	"CY" – County/Parish
70	Location ID Code	County of residential address.
71	Date Time Period Format Qualifier	"D8" CCYYMMDD
71	Member Birth Date	Client date of birth
72	Gender Code	"M" – Male "F" – Female "U" – Unknown
72	Composite Race or Ethnicity Information	
73	Race or Ethnicity Code	"7" Not Provided "8" Not Applicable "A" Asian or Pacific Islander "B" Black "C" Caucasian "D" Subcontinent Asian American "E" Other Race or Ethnicity "F" Asian Pacific American "G" Native American "H" Hispanic "I" American Indian or Alaskan Native "J" Native Hawaiian "N" Black (Non-Hispanic) "O" White (Non-Hispanic) "P" Pacific Islander "Z" Mutually Defined
81	Health Related Code	"T" – Tobacco Use
83	Identification Code Qualifier	"LE" ISO 639 Language Codes
84	Language Code	

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Page	Data Element	Values / Comments
87	Subscriber Last Name	Incorrect member name was sent
87	Subscriber First Name	Incorrect member name was sent
87	Subscriber Middle Name	Incorrect member name was sent
90	Date Time Period	Incorrect DOB was sent
90	Gender Code	Incorrect gender code was sent
90	Composite Race or Ethnicity Information	Incorrect Race or Ethnicity information sent “7” Not Provided “8” Not Applicable “A” Asian or Pacific Islander “B” Black “C” Caucasian “D” Subcontinent Asian American “E” Other Race or Ethnicity “F” Asian Pacific American “G” Native American “H” Hispanic “I” American Indian or Alaskan Native “J” Native Hawaiian “N” Black (Non-Hispanic) “O” White (Non-Hispanic) “P” Pacific Islander “Z” Mutually Defined
92	Subscriber Address Line	Mailing Address (line 1)
92	Subscriber Address Line	Mailing Address (line 2, if needed)
93	Subscriber City Name	Mailing Address
93	Subscriber State Code	Mailing Address
94	Subscriber ZIP Code	Mailing Address

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Page	Data Element	Values / Comments
122	Responsible Party Last or Org Name	Case head last name.
122	Responsible Party First Name	Case head first name.
122	Responsible Party Middle Name	Case head middle name.
139	Insurance Line Code	“AK” – Mental Health “HMO” – Health Maintenance Organization
140	Plan Coverage Description	Rate code, PG indicator, Co-pay, Waiver Type, Pharmacy Co-pay A – Aging Waiver B – Brain Waiver D – Community Support Waiver T – Tech Dependent Waiver P – Personal Assistant Waiver N – New Choices Waiver M –no waiver, just Medicaid C – in custody of DCFS/JJS U – Autism Waiver
142	Date Time Qualifier	“348” – Benefit Begin “349” – Benefit End
143	Date Time Period Format Qualifier	“D8” if just the beginning date is being sent “RD8” if a span is being sent
143	Coverage Period	CCYYMMDD or CCYYMMDD-CCYYMMDD
152	Entity ID Code	“P3” – Primary Care Provider or Lock-in Physician “QA” – Lock-in Pharmacy “Y2” – Managed Care Organization “80” Hospital “FA” Facility (urgent care)
153	Provider Last or Organization Name	Name relating to entity ID code

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Page	Data Element	Values / Comments
153	Name First	
163	Insured Group or Policy Number	
165	Service Code	"1" Medical care "35" Dental Care "48" Hospital – Inpatient "89" Prescription Drug "AL" Vision
167	Date Time Qualifier	"344" – Coordination of Benefits Begin "345" – Coordination of Benefits End
167	Date Time Period Format Qualifier	"D8"
167	Coordination of Benefits Date	CCYYMMDD
168	Entity Identifier Code	"IN" Insurer
169	Entity Type Qualifier	"2" Non-Person Entity
169	Name Last or Organization Name	Name of Insurance Company

Appendix “A”
834 best practices document for ACO’s

Introduction: This document is being provided to give an understanding of the 834 file. Use this document as a best practices tool for recommendations in what order to work the 834 file. Additionally, this document explains what triggers the information displayed on this file. This file is sent nightly and should be worked on a daily basis. The Sync file is sent monthly.

834 codes:

Work the report in the following order each day (see below for details on each identified code). Code 25, reinstate, is worked last to avoid customers losing coverage.

Daily (file sent nightly – always work this file before the Sync file is received)

- 21 – Add
- 01 – Change
- 24 – Terminate
- 25 – Reinstatement

Monthly (file received once per month, usually on a Sunday evening)

- 30 – Sync File

CODE DETAILS:**21 ADD**

The following reasons generate the 21 code:

- New enrollment
- Auto re-enrollment – client is enrolled but had a loss of eligibility that exceeds one month.
- Spenddown paid – will always display a begin and end date field.
- Retroactive eligibility periods – begin and end date is displayed if eligibility is for a previous month or after benefit select for the same month. Begin date will be displayed and end date field will be blank if it is before benefit select in the current month.

Additional helpful information:

- Code will not show until payment is made to the plan.
- Sort by case numbers in order to keep client information grouped together.
- Always review the date range to be sure action is taken for the correct month(s).
- Never close cases when working the 21 code. Information may be for a retroactive period or may be a monthly spenddown.
- When a customer changes from one program to another, an add code will be sent for the new program eligibility.
 - Changing from CHIP to Medicaid, or Medicaid to CHIP.
 - If category of aid changes, it will be a change code. ie. Chip Plan A to Plan C, or traditional Medicaid to non-traditional Medicaid.

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ACO Example(s): Once an ACO selection is made, the code 21 on the 834 file is sent.

1-Add (new enrollment with retroactive)– Customer made selection on June 7th. 834 file sent June 7th (before benefit issuance for July), customer approved in June for the months of April, May, and June. Current month is open ended:

<i>Name</i>	<i>Begin date</i>	<i>End date</i>	<i>Code</i>
Mr. Smith	01Jun2012		21

2- Add (new enrollment) – Customer made selection on June 28th. 834 file sent end of July at benefit issuance. Customer approved in June for months of April, May, June. August is open ended as the file was sent after July benefit issuance:

<i>Name</i>	<i>Begin date</i>	<i>End date</i>	<i>Code</i>
Mr. Smith	01Aug2012		21

3- Add (spenddown) – Customer applied in June and was approved June. File sent June 5th, spenddown paid for June. And end date will be displayed with a spenddown.

<i>Name</i>	<i>Begin date</i>	<i>End date</i>	<i>Code</i>
Mr. Smith	01June2012	30Jun2012	21

4- Add (newborn) – On June 17th customer reports baby was born on 5/29. Coverage will begin with the baby's date of birth.

<i>Name</i>	<i>Begin date</i>	<i>End date</i>	<i>Code</i>
Baby Smith	29May2012	31May2012	21
Baby Smith	01Jun2012		21

Medicaid Note: The mother's plan will always be matched in the birth month.

CHIP Note: If the mother is on CHIP, the mother's plan will not be matched in the birth month.

01 CHANGE

The following reasons generate the 01 code (a medical card needs to be authorized before the system will identify and send a change):

- Demographic change
 - Name
 - Gender
 - DOB (date of birth)
 - HIB # (Medicare Eligibility #)
- Address change
- Third Party Liability (TPL) or Insurance change
- BUY-IN
- Rate cell
 - Adjustments

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- Pregnancy
- Co-pay

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Additional helpful information:

- This does NOT open a record; **do NOT open or close a record when working changes.**
- Working these before the terminate code leads to less confusion.
- Displays “effective” dates only. **Does not change the eligibility begin or end dates.**
- Look for the change in the display as the exact change is not identified.
- Changes are submitted as an effective date for the first of the current month.

Example(s): use the change information to update the client record. Replace the old information with the new information received for the effective month. Do not add or terminate with this information.

- 1- Coverage change: File received July 9th showing a customer changed from non-traditional to traditional Medicaid coverage. Look at the information received in the change; replace the information for the month of the effective date. This change from non-traditional to traditional will increase their coverage.

Name	Effective Date	Code
Mr. Smith	01July2012	01

- 2- Retroactive change: File received June 9th showing a customer, previously open on non-traditional Medicaid coverage, was changed to traditional Medicaid coverage in the retroactive month of May.

Name	Effective Date	Code
Mr. Smith	01May2012	01

- 3- Address change: File received June 9th showing customer address modified June 8th.

Name	Effective Date	Code
Mr. Smith	01Jun2012	01

24 TERMINATE

The following reasons generate the 24 code:

- End enrollment (change in plan) – retroactive end dates will populate
- Death
- Loss of eligibility – did not show eligibility for the month at time of benefit issuance.
- Premium pull (recoupment)

Additional helpful information:

- End date will be displayed on the file. If a premium is pulled, a new termination will be displayed with a retroactive date.
- Treat these dates as the plan termination date – code 24 end date is a termination date.
- Customer may change their plan or have a change in their coverage area.
- If a customer dies, the health plan should go in and void all encounters for dates after death.

Example(s):

1-End Enrollment- Coverage ends July 31, 2012 (displays end of month date)

Name	Begin date	End date	Code
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- Run a separate report from MMCS to reconcile with a cross check of the 820 premiums payments received.
- Check eligibility month to month to match the files sent monthly.
- View the 834 in MMCS anytime to verify eligibility or obtain clarification on any given individual.

Appendix “B”

834 best practices document for Prepaid Mental Health, CHIP, HOME, and Substance Abuse

Introduction: This document is being provided to give an understanding of the 834 file. Use this document as a best practices tool for recommendations in what order to work the 834 file. Additionally, this document explains what triggers the information displayed on this file. This file is sent nightly and should be worked on a daily basis. The Sync file is sent monthly.

834 codes:

Work the report in the following order each day (see below for details on each identified code). Code 25, reinstate, is worked last to avoid customers losing coverage.

Daily (file sent nightly – always work this file before the Sync file is received)

- 21 – Add
- 01 – Change
- 24 – Terminate
- 25 – Reinstatement

Monthly (file received once per month, usually on a Sunday evening)

- 30 – Sync File

CODE DETAILS:

21 ADD

The following reasons generate the 21 code:

- New enrollment
- Auto re-enrollment – client is enrolled but had a loss of eligibility that exceeds one month.
- Spenddown paid – will always display a begin and end date field.
- Retroactive eligibility periods – begin and end date is displayed if eligibility is for a previous month or after benefit select for the same month. Begin date will be displayed and end date field will be blank if it is before benefit select in the current month.

Additional helpful information:

- Code will not show until payment is made to the plan.
- Sort by case numbers in order to keep client information grouped together.
- Always review the date range to be sure action is taken for the correct month(s).
- Never close cases when working the 21 code. Information may be for a retroactive period or may be a monthly spenddown .

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- When a customer changes from one program to another, an add code will be sent for the new program eligibility.
 - Changing from CHIP to Medicaid, or Medicaid to CHIP.
 - If category of aid changes, it will be a change code. ie. Chip Plan A to Plan C, or traditional Medicaid to non-traditional Medicaid.

Mental Health Centers, CHIP, HOME, and Substance Abuse

Example(s):

1-Add (new enrollment with retroactive)– file sent June 7th, customer approved in June for April, May, and June, before benefit issuance for July. Current month is open ended:

<i>Name</i>	<i>Begin date</i>	<i>End date</i>	<i>Code</i>
Mr. Smith	01Apr2012	30Apr2012	21
Mr. Smith	01May2012	31May2012	21
Mr. Smith	01Jun2012		21

2- Add (new enrollment) – file sent June 28th, customer approved in June for months of April, May, June, and July as it was sent ‘after’ benefit issuance for July. July is open ended as the file was sent after benefit issuance:

<i>Name</i>	<i>Begin date</i>	<i>End date</i>	<i>Code</i>
Mr. Smith	01Apr2012	30Apr2012	21
Mr. Smith	01May2012	31May2012	21
Mr. Smith	01Jun201	30Jun2012	21
Mr. Smith	01Jul2012		21

3- Add (spenddown) – Customer applied in June and was approved for May and June. File sent June 5th, spenddown paid for May and June.

<i>Name</i>	<i>Begin date</i>	<i>End date</i>	<i>Code</i>
Mr. Smith	01May2012	31May2012	21
Mr. Smith	01June2012	30Jun2012	21

01 CHANGE

The following reasons generate the 01 code (a medical card needs to be authorized before the system will identify and send a change):

- Demographic change
 - Name
 - Gender
 - DOB (date of birth)
 - HIB # (Medicare Eligibility #)
- Address change
- Third Party Liability (TPL) or Insurance change
- BUY-IN
- Rate cell
 - Adjustments
 - Pregnancy
 - Co-pay

Additional helpful information:

- This does NOT open a record; **do NOT open or close a record when working changes.**
- Working these before the terminate code leads to less confusion.
- Displays “effective” dates only. **Does not change the eligibility begin or end dates.**
- Look for the change in the display as the exact change is not identified.
- Changes are submitted as an effective date for the first of the current month.

Example(s): use the change information to update the client record. Replace the old information with the new information received for the effective month. Do not add or terminate with this information.

4- Coverage change: File received July 9th showing a customer changed from non-traditional to traditional Medicaid coverage. Look at the information received in the change; replace the information for the month of the effective date. This change from non-traditional to traditional will increase their coverage.

Name	Effective Date	Code
Mr. Smith	01July2012	01

5- Retroactive change: File received June 9th showing a customer, previously open on non-traditional Medicaid coverage, was changed to traditional Medicaid coverage in the retroactive month of May.

Name	Effective Date	Code
Mr. Smith	01May2012	01

6- Address change: File received June 9th showing customer address modified June 8th.

Name	Effective Date	Code
Mr. Smith	01Jun2012	01

24 TERMINATE

The following reasons generate the 24 code:

- End enrollment (change in plan) – retroactive end dates will populate
- Death
- Loss of eligibility – did not show eligibility for the month at time of benefit issuance.
- Premium pull (recoupment)

Additional helpful information:

- End date will be displayed on the file. If a premium is pulled, a new termination will be displayed with a retroactive date.
- Treat these dates as the plan termination date – code 24 end date is a termination date.
- Customer may change their plan or have a change in their coverage area.
- If a customer dies, the health plan should go in and void all encounters for dates after death.

Example(s):

1-End Enrollment- Coverage ends July 31, 2012 (displays end of month date)

Name	Begin date	End date	Code
Mr. Smith		31July2012	24

2- Death- Client passed away April 5, 2012 (displays date of death). Premium remains in place for month of death.

Name	Begin date	End date	Code

Mr. Smith

05Apr2012 24

25 REINSTATE

The following reasons generate the 25 code:

- Loss of eligibility, and then reinstated.
- This will only occur any time after benefit issuance for the current month and through the end of the next month.

Additional helpful information:

- Code is sent when case is closed and then reopened, for the same category of aid, before the end of the next month.
- There will be no gap in coverage.
- Use this to reprocess previously denied claims.

Example(s):

2- Termination file was sent in May. On June 12th, client is again eligible. Reinstatement code (25) is sent to open the client back up.

Name	Begin Date	Code
Mr. Smith	01Jun2012	25

30 SYNC FILE

- Sent once per month and needs to be worked monthly.
- Used as a reconciliation file, or a cross check of eligibility.
 - **Do not use for Add or Terminate.**
- Displays everyone open for the month requested. Displays eligible members found the day the file is run.
 - Example:
 - File is run on the 3rd Sunday for the current month and displays all eligible members found on that day.
 - File is run the 1st Sunday for the previous month, and displays all eligible members for the previous month.
- Date file received varies by plan choice. Files are received to the health plan on Monday morning.
- If discrepancies are found, research MMCS system for clarification. If more information is needed, contact the DOH designee within 30 days of receipt of the sync file.

HELPFUL HINTS FOR HEALTHPLANS:

- Run a separate report from MMCS to reconcile with a cross check of the 820 premiums payments received.
- Check eligibility month to month to match the files sent monthly.
- View the 834 in MMCS anytime to verify eligibility or obtain clarification on any given individual.