HP Enterprise Services

834 Companion Guide – Benefit Enrollment and Maintenance Transaction

Nevada Medicaid Management Information System (NV MMIS)

State of Nevada
Division of Health Care Financing and Policy (DHCFP)
Medicaid Management Information System (MMIS)

In Support of the:
Nevada MMIS Takeover Project
Version 2.2
December 5, 2011

Revision history

08/22/2011	Removed yellow highlighting from email addresses, phone numbers, and various other statements in response to specific deliverable review comments.	2
08/31/2011	Removed Confidentiality and Trademarks section for consistency with similar documentation.	ii
12/05/2011	Takeover HPES	All

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Introduction

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N Health Care Implementation Guides have been established as the standards of compliance and are online at:
http://www.wpc-di.com/HealthCareFinal.asp.

Additional information is on the Department of Health and Human Services website at: http://aspe.hhs.gov/admnsimp/.

Purpose

HP Enterprise Services has prepared this Companion Guide and website, http://medicaid.nv.gov, to support Nevada Medicaid and Nevada Check Up billing. (Hereafter, Nevada Medicaid and Nevada Check Up are referred to as "Medicaid" unless otherwise specified.)

This Companion Guide shows enrollment roster data that HP Enterprise Services provides to Managed Care Organizations (MCOs) via the EDI 834 transaction.

At the end of each month, HP Enterprise Services creates an 834 transaction that contains the next month's recipient list, prospective capitation payment per recipient and provider payment date.

The recipient list is separated into three groups: Additions, Cancellations and Audits. It counts all recipients with at least one day of MCO enrollment in the current or subsequent month.

Ethnicity Codes

The 834 transaction includes a race or ethnicity code in Data Element DMG05, Loop 2100A. Ethnicity codes are listed in the Addenda to the 4010 Implementation Guide (IG) for the 834 transaction.

Language Codes

The 834 transaction includes the ISO 639 language codes. The codes are sent in the LUI02 segment, Loop 2100A with LUI01 as "LE."

ST/SE and ISA/ISE Envelopes

Additions, Cancellations and Audits are each listed in their own, separate ST/SE envelope. All three groups are contained in one ISA/ISE envelope. The intent of this structure is to clearly identify enrollment changes. Recipients who appear on the Addition list will also appear on the Audit list because they are participants for that month, and they are new Additions.

Questions?

For technical questions regarding claim submission or testing, call the Electronic Commerce Customer Support Help Desk at (800) 924-6741.

For enrollment or setup questions, please contact HP Enterprise Services EDI Coordinator at nvmmis.EDIsupport@hp.com , (877) 638-3472.

Revision History

In the following table, information that has changed since the last version of this Companion Guide is highlighted yellow. In addition, Data Element DTP03 on IG page 34 was removed from this Companion Guide.

834 Benefit Enrollment and Maintenance Transaction

Page	Loop	Segment	Data Element	Comments
183		ISA	ISA01: Authorization Information Qualifier	"00" = No Authorization Information Present
184		ISA	ISA03: Security Information Qualifier	"00" = No Security Information Present
184		ISA	ISA05: Interchange ID Qualifier	"ZZ" = Mutually Defined
184		ISA	ISA06: Interchange Sender	"NVD FHSC FA"
184		ISA	ISA07: Interchange ID Qualifier	"ZZ" = Mutually Defined
185		ISA	ISA08: Interchange Receiver	Medicaid Service Center
185		ISA	ISA12: Interchange Control Version Number	"00401" = Version Number
186		ISA	ISA14: Acknowledgment Requested	"0" = No Acknowledgment Requested
186		ISA	ISA16: Component Element Separator	">"
188		GS	GS02: Application Sender's Code	"NVD FHSC FA"
188		GS	GS03: Application Receiver's Code	4-digit Service Center code
189		GS	GS08: Version/Release/Industry Identifier Code	"004010X095A1"
27		ST	ST02: Transaction Set Control Number	Additions, Cancellations and Audit records will be in separate lists enclosed in separate SE/SA envelopes.
31		BGN	BGN08: Action Code	"2" = Additions or Cancellations "4" = Audits
32		REF	REF01: Ref ID Qualifier	"38" = Master Policy Number

Page	Loop	Segment	Data Element	Comments
32		REF	REF02: Reference ID	10-digit MCO API
36	1000A	N1	N102: Plan Sponsor Name (P5)	"Division of Health Care Financing and Policy"
36	1000A	N1	N104: ID Code	"549999919"
38	1000B	N1	N102: Insurer Name (IN)	Provider's name
38	1000B	N1	N104: ID Code	Provider's Federal Tax ID Number
44	2000	INS	INS03: Maintenance Type Code	Additions (021), Cancellations (024) and Audit records (030) will occur in separate ST/SE envelope groups. A maximum of 10,000 INS segments can occur in one ST/SE envelope.
51	2000	REF	REF01: Ref ID Qualifier	"0F" = Subscriber Number
52	2000	REF	REF02: Reference ID	11-digit Recipient ID
55	2000	REF	REF01: Ref ID Qualifier	"17" = Client reporting category
55	2000	REF	REF02: Reference ID	Program designation code
59	2000	DTP	DTP02 (356): Eligibility Begin Date	The Medicaid Eligibility Begin Date occurs with Additions and Audit records.
59	2000	DTP	DTP02 (357): Enrollment End Date	The MCO Enrollment End Date is reflected at the Member Level on Cancellation records.
129	2300	HD	HD03: Insurance Line Code	"HMO" = Health Maintenance Organization
130	2300	HD	HD04: Plan Coverage Description	Benefit Plan package code
133	2300	DTP	DTP02 (348): Enrollment Begin Date	MCO Enrollment Begin Date occurs for Additions and Audit records.

Page	Loop	Segment	Data Element	Comments
134	2300	AMT	AMT01: Amount Qualifier Code	"P3" = Premium Amount
134	2300	AMT	AMT02: Monetary Amount	Capitation Amount
150	2320	COB	COB01: Payer Responsible Sequence Code	**Loop 2320 can occur 5 times and provide information to a Third Party Administrator.** If HE-TPL-COVERAGE-CD = A (Medicare A), B (Medicare B), D (Dental), H (Hospitalization), K (Medicare Extended), L (Managed Care), M (Major Medical), P (Physician), R (Pharmacy), U (Uninsured Parent), Y (Medicare A – MCO), or Z (Medicare B – MCO), then COB01 = "P", else COB01 = "S."
151	2320	COB	COB02: Reference ID	Third Party Liability (TPL) policy number
151	2320	COB	COB03: COB Code	"1" = Coordination Of Benefits (COB)
152	2320	REF	REF01: Reference ID Qualifier	"60" = Coverage Code Qualifier
152	2320	REF	REF02: Reference ID	TPL coverage type
156	2320	DTP	DTP01: Date/Time Qualifier	"344" = COB Begin Date
157	2320	DTP	DTP03: Date Time Period	TPL begin date
156	2320	DTP	DTP01: Date/Time Qualifier	"345" = COB End Date
157	2320	DTP	DTP03: Date Time Period	TPL end date