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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15. 5010 834 STANDARD COMPANION GUIDE

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

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

15. 5010 834 STANDARD COMPANION GUIDE

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

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	LD	NISO Z39.53 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

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

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***
	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:

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

				'17' - Client Reporting Category '9V' - Payment Category 'CE' - Class of Contract Code '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 1st 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

			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 resident – 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

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

			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

	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.

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		

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

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

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 – Alternate Format Selection				
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

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.

*** 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

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.

15. 5010 834 STANDARD COMPANION GUIDE

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

15. 5010 834 STANDARD COMPANION GUIDE

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.

15. 5010 834 STANDARD COMPANION GUIDE

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 12th 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.

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.

15. 5010 834 STANDARD COMPANION GUIDE

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.