Indiana Health Coverage Programs

HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides
Based on ASC X12 version 005010

Health Care Eligibility Benefit Inquiry and Response (270/271)

Companion Guide Version Number: 3.5
Revision Date: July 2019
Preface

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with the IHCP. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.
# Table of Contents

1 INTRODUCTION ..................................................................................................................................................................................5  
  1.1 SCOPE .........................................................................................................................................................................................6  
  1.2 OVERVIEW ...................................................................................................................................................................................6  
  1.3 REFERENCES ................................................................................................................................................................................6  
  1.4 ADDITIONAL INFORMATION ........................................................................................................................................................7  

2 GETTING STARTED .............................................................................................................................................................................7  
  2.1 WORKING WITH THE IHCP .........................................................................................................................................................7  
  2.2 TRADING PARTNER REGISTRATION ........................................................................................................................................7  
  2.3 CERTIFICATION AND TESTING OVERVIEW ...........................................................................................................................7  

3 TESTING WITH THE PAYER ...............................................................................................................................................................8  

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS ..................................................................................................................9  
  4.1 PROCESS FLOWS .........................................................................................................................................................................9  
  4.2 TRANSMISSION ADMINISTRATIVE PROCEDURES ....................................................................................................................9  
  4.3 COMMUNICATION PROTOCOL SPECIFICATIONS ................................................................................................................10  
  4.4 PASSWORDS ................................................................................................................................................................................10  

5 CONTACT INFORMATION ................................................................................................................................................................10  
  5.1 DXC EDI TECHNICAL ASSISTANCE ........................................................................................................................................10  
  5.2 PROVIDER SERVICE .................................................................................................................................................................11  
  5.3 APPLICABLE WEBSITES/E-MAIL ..............................................................................................................................................11  

6 CONTROL SEGMENTS/ENVELOPES ..................................................................................................................................................11  
  6.1 ISA - IEA .......................................................................................................................................................................................11  
  6.2 GS – GE .......................................................................................................................................................................................11  

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS ...............................................................................................................12  
  7.1 ELIGIBILITY INQUIRY (270 INBOUND) SEARCH OPTIONS ......................................................................................................12  
  7.2 FILE STRUCTURE .........................................................................................................................................................................12  
  7.3 ELIGIBILITY INQUIRY (270 INBOUND) PROCESSING GUIDELINES ..........................................................................................12  
    7.3.1 NPI CROSSWALK VALIDATION ........................................................................................................................................12  
    7.3.2 MISCELLANEOUS GUIDELINES ........................................................................................................................................12  
  7.4 ELIGIBILITY RESPONSE (271 OUTBOUND) BASIC ELIGIBILITY AND BENEFIT LIMITATIONS ................................................13  

8 ACKNOWLEDGEMENTS AND/OR REPORTS ........................................................................................................................................18  

9 TRADING PARTNER AGREEMENTS ....................................................................................................................................................18  

10 TRANSACTION SPECIFIC INFORMATION ........................................................................................................................................19  
  10.1 005010X279A1 Health Care Benefit Inquiry (270) ..................................................................................................................19  
  10.2 005010X279A1 Health Care Benefit Information (271) ...........................................................................................................22  

11 APPENDICES .....................................................................................................................................................................................27  
  11.1 IMPLEMENTATION CHECKLIST .................................................................................................................................................27  
  11.2 CHANGE SUMMARY .................................................................................................................................................................27
### 1 INTRODUCTION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that the Indiana Health Coverage Programs has something additional, over and above, the information in the IGs. That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the IGs internal code listings
- Clarify the use of loops, segments, composite and simple data elements

Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with the IHCP.

In addition to the row for each segment, one or more additional rows are used to describe the IHCP’s usage for composite and simple data elements and for any other information. Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from the IHCP for specific segments provided by the TR3 Implementation Guides. The following is an example of the type of information that would be elaborated on in Section 10: Transaction Specific Information.

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>193</td>
<td>2100C</td>
<td>NM1</td>
<td>Subscriber Name</td>
<td></td>
<td></td>
<td>This type of row always exists to indicate that new segment has begun. It is always shaded at 10% and notes or comments about the segment itself goes in this cell.</td>
</tr>
<tr>
<td>195</td>
<td>2100C</td>
<td>NM109</td>
<td>Subscriber Primary Identifier</td>
<td>15</td>
<td></td>
<td>This type of row exists to limit the length of the specified data element.</td>
</tr>
<tr>
<td>196</td>
<td>2100C</td>
<td>REF</td>
<td>Subscriber Additional Identification</td>
<td></td>
<td></td>
<td>These are the only codes transmitted by the IHCP.</td>
</tr>
<tr>
<td>197</td>
<td>2100C</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>18, 49, 6P, HJ, N6</td>
<td></td>
<td>This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not population the first 3 columns makes it clear that the code value belongs to the row immediately above it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plan Network Identification</td>
<td>N6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>218</td>
<td>2110C</td>
<td>EB</td>
<td>Subscriber Eligibility or Benefit Information</td>
<td></td>
<td></td>
<td>This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.</td>
</tr>
<tr>
<td>231</td>
<td>2110C</td>
<td>EB13-1</td>
<td>Product/Service ID Qualifier</td>
<td>AD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.1 SCOPE
The transaction instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instruction in this companion guide are not intended to be stand-alone requirements 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 statements.

1.2 OVERVIEW

1.2.1 Overview of HIPAA Legislation
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

1.2.2 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).

1.2.3 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.

1.3 REFERENCES
In addition to the resources available on the Indiana Medicaid Provider Website (http://provider.indianamedicaid.com/), there are other websites that contain helpful information to assist in the implementation of the electronic data interchange process. Links to these websites are listed below and are separated by category for easy reference.

1.3.1 Government and Other Associations
Center for Medicare and Medicaid Services (CMS): http://www.cms.hhs.gov
WEDI – Workgroup for Electronic Data Interchange: http://www.wedi.org

1.3.2 ASC X12 Standards
Data Interchange Standards Association: http://disa.org
American Nation Standards Institute: http://ansi.org
Accredited Standards Committee: http://www.x12.org
1.4 ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X 12 standard is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers.

The intended audience for this companion guide is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

National Provider Identifier
As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier. The NPI replaces all payer-specific identification numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that should be submitted on these transactions from a health care provider.

For all non-healthcare providers where an NPI is not assigned, the Medicaid provider number should be submitted.

For additional information, Trading Partner Information can be found in the Electronic Data Interchange section on the Indiana Medicaid Provider Website: http://provider.indianamedicaid.com/general-provider-services/electronic-data-interchange-(edi)-solutions.aspx.

2 GETTING STARTED

2.1 WORKING WITH THE IHCP
Indiana Medicaid Trading Partners exchange electronic health care transactions with DXC Technology via the Secure File Transfer Protocol-SFTP (File Exchange) or HTTPS/S Web Services connection. After establishing a transmission method, each trading partner must successfully complete testing. Additional information is provided in Section 3 of this companion guide. Trading Partners are permitted to enroll for Production connectivity after successful completion of testing.

2.2 TRADING PARTNER REGISTRATION
All trading partners enrolling for Production connectivity are required to complete the IHCP Trading Partner Profile and Agreement (TPA) located on the IHCP Provider Website http://provider.indianamedicaid.com → Electronic Data Interchange.

Those trading partners that are using a currently enrolled billing agent, clearinghouse, or software vendor do not need to enroll separately. Only one trading partner ID is assigned per submitter location per connection type. If multiple trading partners are needed for the same address location please attach a letter to the TPA explaining the need for the additional trading partner ID. Providers must use the Indiana HealthCare Portal to delegate a clearinghouse, billing agent or software vendor access to retrieve their 835 (Electronic Remittance Advice). Information on how to delegate access is found in the Portal User Account Management Guide.

Current Trading Partners that would like to request an update to their existing account must complete the IHCP Trading Partner Profile.

2.3 CERTIFICATION AND TESTING OVERVIEW
The Health Insurance Portability and Accountability Act (HIPAA) requires that all healthcare organizations that exchange HIPAA transaction data electronically with the Indiana Health Coverage Programs (IHCP) establish an electronic data interchange (EDI) relationship. All entities requesting to exchange data with the IHCP must be tested and approved by the IHCP before production transmission begins.
Vendors must review the X12N transaction HIPAA implementation guides and the IHCP Companion Guides to carefully assess the changes needed to their businesses and technical operations to meet the requirements of HIPAA. The national X12N transaction HIPAA implementation guides are available on the Washington Publishing Company site at wpc-edi.com.

3 TESTING WITH THE PAYER
The following steps describe the testing process for EDI vendors that have not yet been approved by the IHCP.

1. **Complete the Trading Partner Profile**
   The IHCP requires each testing entity exchanging data directly with the IHCP to complete and submit the IHCP Trading Partner Profile located on the IHCP Provider Website http://provider.indianamedicaid.com Electronic Data Interchange to initiate the testing process. When the IHCP receives the profile form, testing information is sent to the vendor. Follow the instructions received in the testing information to ensure accuracy and completeness of testing.

2. **Conduct application development**
   Trading Partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional and mutually defined components of the transaction. The vendor must modify its business application systems to comply with the IHCP Companion Guides.

3. **Test each transaction**
   Connectivity testing performed with the transmissions ensures a successful connection between the sender and receiver of data.

   Two levels of data testing are required:
   - **Compliance Testing**
     All transactions must pass data integrity, requirements, balancing, and situational compliance testing. Although third-party HIPAA certification is not required, the preceding levels of compliance are required and must be tested. Compliance is accomplished when the transaction is processed without errors. The software used by the IHCP for compliance checking and the translation of the HIPAA transaction is Edifecs.
   - **IHCP Specification Validation Testing**
     Specification validation testing ensures conformity to the IHCP Companion Guides. This testing ensures that the segments or records that differ based on certain healthcare services are properly created and produced in the transaction data formats. Validation testing is unique to specific relationships between entities and includes testing field lengths, output, security, load/capacity/volume, and external code sets.

4. **Become an IHCP-approved software vendor**
   The testing and approval process differs slightly for software developers, billing services, and clearinghouses. The processes are described in the following subsections.

   **Software Developers**
   Entities whose clients will be submitting directly to the IHCP are not required to become IHCP trading partners. When testing and approval are complete, the IHCP sends certification of approval to the software developer. On receipt of this approval, the software developer should inform its clients that its software has been approved. However, providers are required to complete the procedures outlined in Trading Partner Registration Procedure enroll for production connectivity.

   **Billing Services, Clearinghouses, and Managed Care Entities**
   At completion of testing and approval, a certification of approval notification is sent to the vendor. Billing services, clearinghouses, and managed care entities (MCEs) must submit a signed IHCP Trading Partner Agreement. The trading partner agreement is a contract between parties that have chosen to become electronic business partners. This document stipulates the general terms and conditions under which the partners agree to exchange information electronically. The signed Trading Partner Agreement must be emailed to INXIXTradingPartner@dxc.com or faxed to (317) 488-5185.
4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

4.1 PROCESS FLOWS

The response to a batch and interactive 270 eligibility inquiry will consist of the following:

1. First level response: A TA1 will be returned when errors occur in the envelope (ISA-IEA) segments. A 999 or 271 will not be returned. Please see the IHCP TA1-999 Companion Guide for more information. 
   http://provider.indianamedicaid.com/media/171213/ta1-999%20ihcp%205010%20companion%20guide_v1.3.pdf

2. Second level response: A 999 acknowledgment will be returned reporting acceptance or rejection errors for individual inquiries and transaction sets. Rejected inquiries and transaction sets will not receive a 271 response. Please see the IHCP TA1-999 Companion Guide for more information.
   http://provider.indianamedicaid.com/media/171213/ta1-999%20ihcp%205010%20companion%20guide_v1.3.pdf

3. Third level response: A 271 will be returned for all accepted inquiries with eligibility and benefits information or AAA errors.

Each transaction is validated to ensure compliance with the 005010X279A1 TR3 Implementation Guide.

Transactions that fail this compliance will return a rejection status on the 999 acknowledgement with the error information indicating the compliance error. Transactions that pass this compliance will return an accepted status on the 999 acknowledgement and continue to next level processing.

4.2 TRANSMISSION ADMINISTRATIVE PROCEDURES

The IHCP is available only to authorized users. Submitters must be IHCP Trading Partners. A submitter is authenticated using a Username and Password assigned to the Trading Partner.

System Availability
The system is typically available twenty-four hours a day, seven days a week with the exception of scheduled maintenance windows. Scheduled maintenance information will be posted to the IHCP MOVEit (File Exchange) server at: https://sftp[indianamedicaid.com in the announcements section.
Transmission File Size
- Interactive
  - Only one patient request per transaction set is permitted. One patient is defined as one subscriber loop in the entire transaction set.
  - Only one provider request is permitted per transaction set. One provider is defined as one provider loop in the entire transaction.
- Batch
  - To optimize processing time, the IHCP recommends limiting the number of patient requests per transaction set (ST-SE) to 25 with a maximum of 20,000 requests per file.
  - Up to 20 service type codes can be sent. If more than 20 are sent a AAA segment with error code 33 will be returned on the 271 response.

File Naming Convention
Batch Inbound File naming Convention Policy:
1. All inbound filenames must have an extension. For example: <filename>.txt or <filename>.X12
2. All inbound filenames must not contain invalid characters from the list below
   
   / / " " < > | : ? * , { } ~ $ @ ( ) # & ^ ! % = + ;`
3. All inbound filenames must not contain any spaces

4.3 COMMUNICATION PROTOCOL SPECIFICATIONS
FTPS and SFTP using:
- CAQH CORE compliant web services - Batch and Interactive 270/271.
- MOVEit / File Exchange – Batch 270/271 only.

More information can be found in the IHCP Communications Guide at:
http://provider.indianamedicaid.com/media/171216/ihcp%20communications%20guide%20v3.2.pdf

4.4 PASSWORDS
By connecting to the IHCP File Exchange server, Trading Partners agree to adhere to the password policy including changing passwords every 90-days. Trading Partners are responsible for managing their own data. Each Trading Partner is responsible for managing access to their organization’s data through the IHCP security function. The contact on file for the login/user ID will receive a notification five days before the password expires and is required to manually log in and change the password. Accounts will be locked during the five-day period until the password is changed. Accounts will be disabled if the password is not changed within the five-day period. Locked and disabled accounts will cause automated connection scripts to receive an error and fail to connect. When the password is manually changed in File Exchange, the same change must be applied to all automated scripts to ensure uninterrupted service.

5 CONTACT INFORMATION
5.1 DXC EDI TECHNICAL ASSISTANCE
PHONE: 1-800-457-4584, option 3, and then option 2
FAX: (317) 488-5185
EMAIL: INXIXTradingPartner@dxc.com
5.2 PROVIDER SERVICE
PHONE: 1-800-457-4584, please listen to the entire message before making your selection.

5.3 APPLICABLE WEBSITES/E-MAIL
Indiana Medicaid Provider Website: http://provider.indianamedicaid.com/
The Trading Partner web page can be found under the Electronic Data Interchange section of the Indiana Medicaid Provider Website: http://provider.indianamedicaid.com/general-provider-services/electronic-data-interchange-(edi)-solutions.aspx
All other contact information is listed under the contact us section of the Indiana Medicaid Provider Website: http://provider.indianamedicaid.com/about-indiana-medicaid/contact-us.aspx

6 CONTROL SEGMENTS/ENVELOPES

6.1 ISA - IEA
Eligibility Inquiry (270 Inbound) Interchange Control Header
• ISA06 (Interchange Sender ID): This is the four-byte sender ID assigned by the IHCP.
• ISA08 (Interchange Receiver ID): Required value is IHCP.
• ISA13 (Interchange Control Number): Must be unique per file.

Eligibility Response (271 Outbound) Interchange Control Header
• ISA06 (Interchange Sender ID): IHCP
• ISA08 (Interchange Receiver ID): This is the four-byte sender ID assigned by the IHCP.

6.2 GS – GE
Eligibility Inquiry (270 Inbound) Functional Group Header
• GS02 (Application Sender Code): This is the four-byte sender ID assigned by the IHCP.
• GS03 (Application Receiver’s Code): Required value is IHCP.

Eligibility Response (271 Outbound) Functional Group Header
• GS02 (Application Sender Code): IHCP
• GS03 (Application Receiver’s Code): This is the four-byte sender ID assigned by the IHCP.
7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS
All references to the IHCP in this Companion Guide refer to the Indiana Health Coverage Programs. All references to the IHCP Provider Identifier in this Companion Guide refer to the Indiana Medicaid Provider Service Location Number assigned by IHCP.

7.1 ELIGIBILITY INQUIRY (270 INBOUND) SEARCH OPTIONS
1. Member ID – Loop 2100C NM109
2. Member Name and Date of Birth
   Member Name – Loop 2100C NM103 and NM104
   Date of Birth – Loop 2100C DMG02
3. Member Social Security Number (SSN) and Date of Birth
   SSN (Qualifier SY) – Loop 210C REF02
   Date of Birth – Loop 2100C DMG02

7.2 FILE STRUCTURE
- One interchange per file (ISA/IEA)
- One functional group per file (GS/GE)
- Multiple Transaction Sets per file are accepted (ST/SE)

7.3 ELIGIBILITY INQUIRY (270 INBOUND) PROCESSING GUIDELINES

7.3.1 NPI CROSSWALK VALIDATION
With the implementation of NPI, transactions must be submitted with the NPI for health care providers. Atypical providers may submit with either an NPI or IHCP Provider Identifier.

The IHCP uses a crosswalk to establish a unique match between a Provider’s NPI and IHCP Provider Identifier. The crosswalk must successfully identify a unique IHCP Provider Service Location for the inquiry to return member eligibility information. Three data elements are used in the crosswalk to identify a unique location if the NPI is associated with multiple service locations:
- NPI – Loop 2100B NM109
- Taxonomy Code (if sent) – Loop 2100B PRV03
- Provider Service Location Zip Code – Loop 2100B N403

If the crosswalk does not establish a unique service location, the inquiry will receive a 271 response with reject reason code 043 in Loop 2100B AAA03.

7.3.2 MISCELLANEOUS GUIDELINES
- Active status for members and providers is based on the dates of service submitted in the eligibility inquiry (270):
  - Members not active for dates of service submitted in the inquiry will receive a 271 response with EB01=06.
  - Providers not active for dates of service submitted in the inquiry will receive a 271 response with reject reason code 052 in Loop 2100B AAA03.
- If the member is identified as having a primary care provider, the physician identified must be contacted to determine whether a referral is needed.
- If a member is identified as a risk based managed care member, the managed care entity (MCE) identified in the response must be contacted for more specific program information.
- Consult the IHCP Provider Manual, especially Chapter 2: Member Eligibility and Services, Chapter 6: Prior Authorization and Chapter 8: Billing Instructions.
7.4 ELIGIBILITY RESPONSE (271 OUTBOUND) BASIC ELIGIBILITY AND BENEFIT LIMITATIONS

7.3.1 ELIGIBILITY

- EB01 = 1 – Active Coverage
- EB03 = Covered Service Type Codes
- EB04 = MC – Medicaid
- EB05 = Plan Coverage Description
- DTP01=307, DTP02=RD8 and DTP03= Covered Eligibility Date(s).
- Multiple Eligibility segments use the DTP segments in the Subscriber Eligibility/Benefit Date level. All other elements are populated the same as a single eligibility segment.
- MSG01 = Text field: Please see the IHCP Provider Manual – Please consult the manual for more information.
- MSG01 = Text field: PARTIAL – Partial coverage. All programs other than Full Medicaid and Package A.

7.3.2 NON-COVERED ELIGIBILITY

- EB01 = I – Non-Covered
- EB03 = Non-Covered Service Type Codes
- EB04 = MC – Medicaid
- EB05 = Plan Coverage Description
- DTP01=307, DTP02=RD8 and DTP03= Non-Covered Eligibility Date(s).
- Multiple Eligibility segments use the DTP segments in the Subscriber Eligibility/Benefit Date level. All other elements are populated the same as a single eligibility segment.
- MSG01 = Text field: Please see the IHCP Provider Manual – Please consult the manual for more information.
- MSG01 = Text field: PARTIAL – Partial coverage. All programs other than Full Medicaid and Package A.

7.3.3 MEMBER NOT ELIGIBLE

- EB01 = 06 – Inactive
- DTP01=307, DTP02=RD8 and DTP03= Inactive Eligibility Date(s).

7.3.4 PRIMARY CARE PHYSICIAN

- NM101 = P3 – Primary Care Provider
- NM102 = 1 – Person, 2 – Business Entity
- NM103 = Primary Care Physician’s Last Name or Business Entity Name
- NM104 = Primary Care Physician’s First Name
- NM108 = XX – NPI, SV – IHCP Provider Identifier
- NM109 = Primary Care Physician Provider’s Identifier
- PER01 = IC – Information Contact
- PER03 = TE – Telephone Number
- PER04 = Primary care provider’s phone number beginning with a three digit area code

7.3.5 MANAGED CARE

- EB01 = MC – Managed Care Coordinator
- EB04 = HM – Health Maintenance Organization
- EB05 = Text field that indicates the following:
  - Hoosier Healthwise Managed Care
  - Healthy Indiana Plan Managed Care
  - Hoosier Care Connect
  - Program of All-Inclusive (PACE) Managed Care
• Multiple Managed Care segments use the DTP segments in the Subscriber Eligibility/Benefit Date level. All other elements are populated the same as a single eligibility segment. DTP01=307, DTP02=RD8 and DTP03=managed care eligibility dates.
  
• NM101 = P5 – Plan Sponsor
• NM102 = 2 – Business Entity
• NM103 = Manage Care or PACE Entity’s Name / Managed Care Network Assignment - If Applicable
• NM108 = SV
• NM109 = Managed Care or PACE Entity Identifier
• PER01 = IC – Information Contact
• PER03 = TE – Telephone Number
• PER04 = Managed Care or PACE Entity’s phone number beginning with the three digit area code

7.3.6 PROVIDER RESTRICTION

• EB01 = N – Services Restricted to Following Provider
• EB05 = Text field that contains the benefit program description for restricted services
• NM101 = 1P – Provider
• NM102 = 1 – Person, 2 – Business Entity
• NM103 = Restricted Provider’s Last Name or Business Entity Name
• NM104 = Restricted Provider’s First Name
• NM108 = XX – NPI, SV – IHCP Provider Identifier
• NM109 = Restricted Provider’s Identifier
• PER01 = IC – Information Contact
• PER03 = TE – Telephone Number
• PER04 = Restricted Provider’s phone number beginning with the three digit area code

➢ A restricted EB loop can have multiple occurrences. The program displays all of them if it is not over the 50 EB limit.

7.3.7 THIRD PARTY LIABILITY

• EB01 = R – Other or Additional Payer
• EB04 – C1 – Commercial
• EB05 = Text field indicating one of the TPL coverage types in the Indiana Core MMIS, for example, Major Medical
• REF01 = IG – Insurance Policy Number
• REF02 = Subscriber’s Insurance Policy Number
• REF01 = 6P – Group Number
• REF02 = Subscriber’s Insurance Group Number
• REF01 = 18 – Plan Number
• REF02 = Subscriber’s Insurance Carrier Code
• NM101 = 2B – Third Party Administrator
• NM102 = 2 – Business Entity
• NM103 = Third Party Organization’s Name

➢ The coverage type can loop multiple times for a given recipient. All of the TPL information is populated the same as in the first occurrence, but with a different coverage code. All coverage types are displayed unless the EB segment is over the 50 EB limit. Each type of coverage is reflected in a separate TPL segment even if the coverage is under the same policy.

➢ TPL coverage types are as follows:
  ▪ Cancer
  ▪ Dental
  ▪ Home Health
  ▪ Hospitalization
• Indemnity
• Intermediate Care in a Nursing Facility
• Major Medical
• Medical
• Medicare Supplemental Insurance
• Mental Health
• Optical/Vision
• Pharmacy
• Skilled Care in a Nursing Facility

7.3.8 MEDICARE

• EB01 = R – Other or Additional Payer
• EB04 = MA – Member has Medicare A coverage
• EB04 = MB – Member has Medicare B coverage
• EB04 = OT – Other (Member has Medicare D coverage)
• REF01 = F6 – Health Insurance Claim Number
• REF02 = Member’s Medicare Number

✓ A Medicare segment is sent for each Medicare coverage a member has.

➢ Example 1 – A member has Medicare A coverage only. One Medicare segment is sent on the 271 transaction.
  o EB01 = R – Other or Additional Payer
  o EB04 = MA – Recipient has Medicare A coverage
  o REF01 = F6 – Health Insurance Claim Number
  o REF02 = Member’s Medicare Number

➢ Example 2 – A member has Medicare A and B coverage. Two Medicare segments are sent on the 271 transaction.
  o Segment 1:
    ▪ EB01 = R – Other or Additional Payer
    ▪ EB04 = MA – Recipient has Medicare A coverage
    ▪ REF01 = F6 – Health Insurance Claim Number
    ▪ REF02 = Member’s Medicare Number
  o Segment 2:
    ▪ EB01 = R – Other or Additional Payer
    ▪ EB04 = MB – Recipient has Medicare B coverage
    ▪ REF01 = F6 – Health Insurance Claim Number
    ▪ REF02 = Member’s Medicare Number

➢ Example 3 – A member has Medicare A, B and D coverage. Three Medicare segments are sent on the 271 transaction.
  o Segment 1:
    ▪ EB01 = R – Other or Additional Payer
    ▪ EB04 = MA – Recipient has Medicare A coverage
    ▪ REF01 = F6 – Health Insurance Claim Number
    ▪ REF02 = Member’s Medicare Number
  o Segment 2:
    ▪ EB01 = R – Other or Additional Payer
    ▪ EB04 = MB – Recipient has Medicare B Coverage
    ▪ REF01 = F6 – Health Insurance Claim Number
    ▪ REF02 = Member’s Medicare Number
  o Segment 3:
    ▪ EB01 = R – Other or Additional Payer
    ▪ EB04 = OT – Other (Subscriber has Medicare D coverage)
    ▪ REF01 = F6 – Health Insurance Claim Number
    ▪ REF02 = Member’s Medicare Number
7.3.9 QUALIFIED MEDICARE BENEFICIARY (QMB)

- EB05 = Qualified Medicare Beneficiary
  - When no additional program benefits are returned the member is QMB Only
    - Example:
      EB*1*IND*42*MC*Qualified Medicare Beneficiary~
      DTP*307*RD8*20170101-20170101~
  - When additional program benefits are returned the member is QMB Also
    - Example:
      EB*1*IND*42*MC*Full Medicaid~
      DTP*307*RD8*20170101-20170101~
      EB*1*IND*42*MC*Qualified Medicare Beneficiary~
      DTP*307*RD8*20170101-20170101~

7.3.10 NURSING HOME

The nursing home level of care coverage can loop twice for a given member. All level of care information is populated as in the first occurrence, but with a different level of care in EB05.

- EB01 = X – Health Care Facility
- EB05 = Text message indicating the level of care for the member.
- EB07 = Patient Liability Amount
- NM101 = 1P – Provider
- NM102 = 1 – Person, 2 – Business Entity
- NM103 = Level of Care Provider’s Last Name or Business Entity Name
- NM104 = Level of Care Provider’s First Name
- NM108 = XX – NPI, SV – IHCP Provider Identifier
- NM109 = Level of Care Provider’s Identifier
- Level of care coverage includes the following:
  - Nursing Facility
  - ICF/MR
  - Immediate Level of Care
  - Skilled Level of Care
  - Rehabilitation
  - Waiver
  - Hospice

7.3.11 PATIENT LIABILITY

- EB01 = X – Health Care Facility
- EB04 = PL – Personal
- EB05 = Test message indicating plan coverage
- EB07 = Patient Liability Amount
- DTP01 = 307 – Dates covered
- DTP02 = RD8 – CCYYMMDD format
- DTP03 = Time span covered by the date range requested

7.3.12 WAIVER LIABILITY

The waiver liability coverage will loop twice for a given member.

The first loop will report the net amount for which the member is responsible for per applicable time span (monthly):

- EB01 = Y – Waiver Liability
- EB05 = MEDICAID COST SHARE
- EB06 = 34 – Month
- EB07 = Patient Waiver Responsibility Monthly Net Amount
- DTP01 = 307 – Applicable Date Span
The second loop will report the remaining balance amount for which the member is responsible for per applicable time span (monthly):

- **EB01** = Y – Waiver Liability
- **EB05** = MEDICAID COST SHARE
- **EB06** = 29 – Remaining
- **EB07** = Patient Waiver Responsibility Remaining Balance Amount
- **DTP01** = 307 – Applicable Date Span
- **DTP02** = RD8 – CCYYMMDD format
- **DTP03** = Applicable Time Span

**MSG01** = MONTHLY - Time span applicable to Waiver Liability

**MSG01** = Amount is based on claims processed at the time of this eligibility verification. With the exception (POS) pharmacy claims, member is not required to pay the provider until the member receives the monthly Medicaid/HCBS Spend-down Summary Notice listing.

### 7.3.13 DEPARTMENT OF CORRECTIONS

Inpatient Hospital Services only for members in a County/State/Federal Facility

- **EB01** = 1 – Active Coverage
- **EB05** = Medicaid Inpatient Hospital Services Only
- **DTP01** = 307 – Dates covered
- **DTP02** = RD8 – CCYYMMDD format
- **DTP03** = Time span covered by the date range requested

### 7.3.14 COINSURANCE

- **EB01** = A – Coinsurance
- **EB03** = All service types which have the same coinsurance percent for this benefit plan
- **EB04** = MC – Medicaid
- **EB05** = Text field that contains the benefit program description for coinsurance
- **EB08** = Coinsurance Percentage
- **DTP01**=307, **DTP02**=RD8 and **DTP03**=coinsurance effective date range

### 7.3.15 COPAYMENT

- **EB01** = B - Copayment
- **EB03** = All service types which have the same copay amount for this benefit plan
- **EB04** = MC – Medicaid
- **EB05** = Text field that contains the benefit program description for copayment
- **EB06** = 27 - Visit
- **EB07** = Copayment Amount
- **DTP01**=307, **DTP02**=RD8 and **DTP03**=copayment effective date range

### 7.3.16 DEDUCTIBLE

- **EB01** = C - Deductible
- **EB03** = All service types which have the same deductible amount for this benefit plan
- **EB04** = MC – Medicaid
- **EB05** = Text field that contains the benefit program description for deductible
Indiana Health Coverage Programs
5010 270/271 Eligibility Request/Response

- EB06 = 25 - Contract
- EB07 = Deductible Amount
- DTP01=307, DTP02=RD8 and DTP03=deductible effective date range

7.3.17 LOW INCOME
- EB01 = 1 – Active Coverage
- MSG01 = Text Message: Low Income Indicator = YES

7.3.18 PREGNANCY
- EB01 = 1 – Active Coverage
- MSG01 = Text Message: Pregnancy Indicator = YES

7.3.19 NORMALIZING PATIENT LAST NAME
- MSG01 = Member Last Name Returned Reflects the Name Found in the IHCP System

7.3.20 BENEFIT LIMITS
A benefit limit response will be returned if the member has used quantities or dollars for services.
- EB01 = F
- EB04 = MC – Medicaid
- EB05 = Text field that contains the audit limit code and description
- EB07 = Benefit Amount used
- EB10 = Benefit Quantity used
- MSG = Teeth Sealed

8 ACKNOWLEDGEMENTS AND/OR REPORTS

TA1 Interchange Acknowledgment Outbound
The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelope only. A TA1 Interchange acknowledgment is returned only in the event there are envelope errors. Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code.

999 Functional Acknowledgement
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 requirements 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 statements.

9 TRADING PARTNER AGREEMENTS
The IHCP Trading Partner Agreement is a contract between parties that have chosen to become electronic business partners. The Trading Partner Agreement stipulates the general terms and conditions under which the partners agree to exchange information electronically. If billing providers send multiple transaction types electronically, only one signed Trading Partner Agreement is required. Billing providers must print and complete a copy of the Trading Partner Agreement. The signed copy must be submitted to the IHCP EDI Solutions Unit.

10 TRANSACTION SPECIFIC INFORMATION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that the IHCP has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with the IHCP.

In addition to the row for each segment, one or more additional rows are used to describe the IHCP’s usage for composite and simple data elements and for any other information. Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

### 10.1 005010X279A1 Health Care Benefit Inquiry (270)

<table>
<thead>
<tr>
<th>PAGE NUMBER</th>
<th>LOOP ID</th>
<th>REFERENCE</th>
<th>NAME</th>
<th>CODES</th>
<th>LENGTH</th>
<th>NOTES/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>63</td>
<td>BHT</td>
<td>Beginning of Hierarchical Transaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>BHT03</td>
<td>Reference Identification</td>
<td>IHCP supports a maximum of 15 characters for batch transactions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>2100A</td>
<td>NM1</td>
<td>Information Source Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>2100A</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>P5, PR</td>
<td>IHCP uses P5 when the member is risk-based managed care (RBMC). IHCP uses PR when the member is non-managed care, primary care case management (PCCM), or when the delivery system is unknown.</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>2100A</td>
<td>NM103</td>
<td>Name Last or Organization Name</td>
<td>IHCP uses “Indiana Health Coverage Program”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>2100A</td>
<td>NM109</td>
<td>Identification Code</td>
<td>IHCP uses “IHCP”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>2100B</td>
<td>NM1</td>
<td>Information Receiver Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>2100B</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td>IHCP expects SV to be used by atypical providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78</td>
<td>2100B</td>
<td>Identification Code</td>
<td>IHCP atypical provider identifiers are 10 characters long; nine numeric and one alpha location code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>2100B</td>
<td>N4</td>
<td>Information Receiver City, State, ZIP Code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>2100B</td>
<td>N403</td>
<td>Postal Code</td>
<td>Refer to Section 7.2 for NPI crosswalk</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Indiana Health Coverage Programs  
5010 270/271 Eligibility Request/Response

<table>
<thead>
<tr>
<th>Code</th>
<th>2100B</th>
<th>PRV</th>
<th>Information Receiver Provider Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>84</td>
<td>2100B</td>
<td>PRV</td>
<td>Information Receiver Provider Information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>85</td>
<td>PRV</td>
<td>Reference Identification</td>
<td></td>
</tr>
<tr>
<td>92</td>
<td>2100C</td>
<td>NM1</td>
<td>Subscriber Name</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>2100C</td>
<td>NM1</td>
<td>Identification Code</td>
<td>MI</td>
</tr>
<tr>
<td></td>
<td>122</td>
<td>DTP</td>
<td>Subscriber Date</td>
<td></td>
</tr>
<tr>
<td>123</td>
<td>2100C</td>
<td>DTP</td>
<td>Date Time Period</td>
<td></td>
</tr>
<tr>
<td>124</td>
<td>2110C</td>
<td>EQ</td>
<td>Subscriber Eligibility or Benefit Inquiry</td>
<td></td>
</tr>
<tr>
<td>125</td>
<td>2110C</td>
<td>EQ</td>
<td>Service Type Code</td>
<td></td>
</tr>
</tbody>
</table>

IHCP may need the taxonomy code for a successfully NPI crosswalk. Refer to Section 7.2 for NPI crosswalk processing guidelines.

IHCP only recognizes MI

The IHCP subscriber identification number is 12 digits.

IHCP supports F6, EF and SY

IHCP inquires must contain dates within the same month.

IHCP recognizes and processes up to 20 EQ segments.

IHCP supports the following Service Type Codes:
1 – Medical Care
2 - Surgical
4 – Diagnostic X-ray
5 – Diagnostic Lab
6 – Radiation Therapy
7 – Anesthesia
8 – Surgical Assistance
12 – Durable Medical Equipment Purchase
13 – Ambulatory Service Center Facility
18 – Durable Medical Equipment Rental
20 – Second Surgical Opinion
23 – Diagnostic Dental
24 – Periodontics
25 – Restorative (Dental Cap)
28 – Adjunctive Dental Services
30 – Health Benefit Plan Coverage
33 – Chiropractic
34 – Chiropractic Office Visits

Refer to the IHCP Provider Manual, Chapter 3 for a description of basic eligibility and benefit limitations. Not all codes for benefit limitations are valid for every provider.
<table>
<thead>
<tr>
<th>146</th>
<th>2000D</th>
<th>HL</th>
<th>Dependent Level</th>
<th>The IHCP patient is always the subscriber</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 35 – Dental Care
- 40 – Oral Surgery
- 41 – Routine (Preventive) Dental
- 42 – Home Health Care (Supplies)
- 45 – Hospice
- 47 – Hospital
- 48 – Hospital – Inpatient
- 50 – Hospital – Outpatient
- 51 – Hospital – Emergency Accident
- 52 – Hospital – Emergency Medical
- 53 – Hospital – Ambulatory Surgical
- 56 – Medically-Related Transportation
- 60 – General Benefits (Dental Sealants)
- 62 – MRI/CAT Scan
- 65 – Newborn Care
- 66 – Well Baby Care
- 71 – Audiology Exam
- 73 – Diagnostic Medical
- 76 – Dialysis
- 78 – Chemotherapy
- 80 - Immunizations
- 81 - Routine Physical (Chiropractic Initial)
- 82 – Family Planning
- 86 – Emergency Services
- 88 - Pharmacy
- 93 – Podiatry
- 94 – Podiatry – Office Visits
- 98 – Professional (Physician) Visit – Office
- 99 – Professional (Physician) Visit – Inpatient
- A0 – Professional (Physician) Visit – Outpatient
- A3 – Professional (Physician) Visit - Home
- A6 – Psychotherapy
- A7 – Psychiatric - Inpatient
- A8 – Psychiatric – Outpatient
- AB – Rehabilitation – Inpatient
- AD – Occupational Therapy
- AE – Physical Medicine
- AF – Speech Therapy
- AG – Skilled Nursing Care
- AI – Substance Abuse
- AL – Vision (Optometry)
- AM – Frames
- AO – Lenses
- BG – Cardiac Rehabilitation
- BH – Pediatric
- MH – Mental Health
- UC – Urgent Care
### 10.2 005010X279A1 Health Care Benefit Information (271)

<table>
<thead>
<tr>
<th>PAGE</th>
<th>LOOP ID</th>
<th>REFERENCE</th>
<th>NAME</th>
<th>CODES</th>
<th>LENGTH</th>
<th>NOTES/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>213</td>
<td>2000A</td>
<td>HL</td>
<td>Information Source Level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>214</td>
<td>2000A</td>
<td>HL04</td>
<td>Hierarchical Child Code</td>
<td></td>
<td></td>
<td>IHCP returns a 0 when a source level error occurs in the 270 transaction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Examples of source level errors:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Unrecognized payer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Interactive quantity exceeded</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>also see 2100A AAA03 Reject Reason Codes</td>
</tr>
<tr>
<td>218</td>
<td>2100A</td>
<td>NM1</td>
<td>Information Source Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>218</td>
<td>2100A</td>
<td>NM101</td>
<td>Entity Identifier Code</td>
<td>P5</td>
<td>22</td>
<td>IHCP uses P5 when the member is risk-based (RBMC).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PR</td>
<td></td>
<td>IHCP uses PR when the member is non-managed care, primary care case management (PCCM), or when the delivery system is unknown.</td>
</tr>
<tr>
<td>219</td>
<td>2100A</td>
<td>NM103</td>
<td>Name Last or Organization Name</td>
<td></td>
<td></td>
<td>IHCP uses “Indiana Health Coverage Program”</td>
</tr>
<tr>
<td>220</td>
<td>2100A</td>
<td>NM109</td>
<td>Identification Code</td>
<td></td>
<td></td>
<td>IHCP uses “IHCP”</td>
</tr>
<tr>
<td>232</td>
<td>2100B</td>
<td>NM1</td>
<td>Information Receiver Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>233</td>
<td>2100B</td>
<td>NM102</td>
<td>Entity Type Qualifier</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>234</td>
<td>2100B</td>
<td>NM108</td>
<td>Identification Code Qualifier</td>
<td></td>
<td></td>
<td>IHCP uses SV for atypical providers</td>
</tr>
<tr>
<td>235</td>
<td>2100B</td>
<td>NM109</td>
<td>Identification Code</td>
<td></td>
<td></td>
<td>IHCP atypical provider identifiers are 10 characters long.</td>
</tr>
<tr>
<td>238</td>
<td>2100B</td>
<td>AAA</td>
<td>Information Receiver Request Validation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>239</td>
<td>2100B</td>
<td>AAA03</td>
<td>Reject Reason Code</td>
<td></td>
<td></td>
<td>IHCP returns Reject Reason Code 43 when an IHCP Provider Identifier is sent and the provider is a healthcare provider. NPI is required for all healthcare providers. IHCP returns Reject Reason Code 43 when the NPI crosswalk was unsuccessful.</td>
</tr>
<tr>
<td>243</td>
<td>2000C</td>
<td>HL</td>
<td>Subscriber Level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>245</td>
<td>2000C</td>
<td>HL04</td>
<td>Hierarchical Child Code</td>
<td>0</td>
<td></td>
<td>The IHCP patient is always the subscriber, therefore 0 is always sent</td>
</tr>
<tr>
<td>249</td>
<td>2100C</td>
<td>NM1</td>
<td>Subscriber Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>252</td>
<td>2100C</td>
<td>NM109</td>
<td>Identification Code</td>
<td>12</td>
<td></td>
<td>The IHCP subscriber identifier is 12 digits</td>
</tr>
<tr>
<td>262</td>
<td>2100C</td>
<td>AAA</td>
<td>Subscriber Request Validation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>263</td>
<td>2100C</td>
<td>AAA03</td>
<td>Reject Reason Code</td>
<td></td>
<td></td>
<td>The IHCP returns code 78 for members</td>
</tr>
</tbody>
</table>
who are not in Medicaid (PASRR, MRT, and First Steps). The program does not give eligibility for these members.

<table>
<thead>
<tr>
<th>Code</th>
<th>Segment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>283</td>
<td>2100C</td>
<td>DTP</td>
</tr>
<tr>
<td>284</td>
<td>2100C</td>
<td>DTP03</td>
</tr>
<tr>
<td>289</td>
<td>2110C</td>
<td>EB</td>
</tr>
<tr>
<td>291</td>
<td>2110C</td>
<td>EB01</td>
</tr>
<tr>
<td>293</td>
<td>2110C</td>
<td>EB03</td>
</tr>
<tr>
<td>298</td>
<td>2110C</td>
<td>EB04</td>
</tr>
<tr>
<td>299</td>
<td>2110C</td>
<td>EB05</td>
</tr>
</tbody>
</table>

IHCP returns the 270 transaction creation date if no subscriber date is sent on the 270 transaction.

The IHCP sends up to 50 EB segments.

Refer to the PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS Section 7.3 for explanations of the usage of codes used by IHCP.

Refer to the PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS Section 7.3 for explanations of the usage of codes used by IHCP.

Refer to the PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS Section 7.3 for explanations of the usage of codes used by IHCP.

IHCP populates this element with any of the following:
- Hospice Program; Auth for 1st 90 day period
- Hospice Program; Auth for 2nd 90 day period
- Hospice Pgm; Auth for 3rd period; unlimited 60 day
- Hospice Program; Authorization open ended
- 590 Program
- Aged and Disabled HCBCS Waiver
- ALL Benefit Plans - for error disposition
- Adult Mental Health Habilitation
- Behavioral & Primary Healthcare Coordination
- Cancer
- Medicare A
- Medicare B
- Medicare D
- Children's Mental Health Wraapyrus
- Community Integration and Habilitation HCBS Waiver
- Dental
- Family Planning Eligibility Program
- Hoosier Care Connect
- Hoosier Healthwise Managed Care
- Home Health
- HIP 2.0 Plus
- Healthy Indiana Plan Managed Care
- HIP 2.0 Basic
- HIP 2.0 State Plan Basic
- HIP 2.0 State Plan Plus Copay
- HIP 2.0 State Plan Plus
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP Employer Link</td>
<td></td>
</tr>
<tr>
<td>HIP Maternity</td>
<td></td>
</tr>
<tr>
<td>Hospitalization or Hospital/Surgical</td>
<td></td>
</tr>
<tr>
<td>Presumptive Eligibility Adult</td>
<td></td>
</tr>
<tr>
<td>Indemnity</td>
<td></td>
</tr>
<tr>
<td>Long Term Care</td>
<td></td>
</tr>
<tr>
<td>Full Medicaid</td>
<td></td>
</tr>
<tr>
<td>Medicare Advantage Plan</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>MFP Demonstration Grant HCBS Waiver</td>
<td></td>
</tr>
<tr>
<td>MFP Community Integration and Habilitation</td>
<td></td>
</tr>
<tr>
<td>MFP Traumatic Brain Injury</td>
<td></td>
</tr>
<tr>
<td>MFP PRTF Transition from PRTF</td>
<td></td>
</tr>
<tr>
<td>MFP Transition from State Owned Facility</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>Medical and Hospitalization</td>
<td></td>
</tr>
<tr>
<td>Medicaid Rehabilitation Option</td>
<td></td>
</tr>
<tr>
<td>Medical Review Team</td>
<td></td>
</tr>
<tr>
<td>Medicare Supplemental Plan</td>
<td></td>
</tr>
<tr>
<td>General Intermediate Care in AIDS NF</td>
<td></td>
</tr>
<tr>
<td>MR/DD Specialized Intermediate Care in NF</td>
<td></td>
</tr>
<tr>
<td>AIDS Intermediate Care in NF</td>
<td></td>
</tr>
<tr>
<td>ICF/IID</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Level of Care</td>
<td></td>
</tr>
<tr>
<td>General Skilled Care in AIDS NF</td>
<td></td>
</tr>
<tr>
<td>MR/DD Specialized Skilled Care in NF</td>
<td></td>
</tr>
<tr>
<td>AIDS Skilled Care Unit in NF</td>
<td></td>
</tr>
<tr>
<td>Program of All-Inclusive Care for the Elderly</td>
<td></td>
</tr>
<tr>
<td>Program of All-Inclusive (PACE) Managed Care</td>
<td></td>
</tr>
<tr>
<td>PASRR Mental Illness (MI)</td>
<td></td>
</tr>
<tr>
<td>PASRR Individuals with Intellectual Disability</td>
<td></td>
</tr>
<tr>
<td>Presumptive Eligibility Family Planning Svcs Only</td>
<td></td>
</tr>
<tr>
<td>Medicaid Inpatient Hospital Services Only</td>
<td></td>
</tr>
<tr>
<td>Presumptive Eligibility Package A Standard Plan</td>
<td></td>
</tr>
<tr>
<td>Presumptive Eligibility for Pregnant Women</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Package A-Standard Plan</td>
<td></td>
</tr>
<tr>
<td>Package C-Childrens Health Plan (SCHIP)</td>
<td></td>
</tr>
<tr>
<td>Package E - Emergency Services Only</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility</td>
<td></td>
</tr>
<tr>
<td>PRTF Transition Waiver</td>
<td></td>
</tr>
<tr>
<td>Qualified Disabled Working Individual</td>
<td></td>
</tr>
<tr>
<td>Qualified Individual</td>
<td></td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary</td>
<td></td>
</tr>
<tr>
<td>RCP-Inpatient Hospital</td>
<td></td>
</tr>
<tr>
<td>RCP-Outpatient Hospital</td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>TEAM</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>300</td>
<td>2110C</td>
</tr>
<tr>
<td>317</td>
<td>2110C</td>
</tr>
<tr>
<td>317</td>
<td>2110C</td>
</tr>
<tr>
<td>318</td>
<td>2110C</td>
</tr>
<tr>
<td>322</td>
<td>2110C</td>
</tr>
</tbody>
</table>
IHCP uses the following messages when appropriate:
MSG*Refer to the IHCP Provider Manual~
MSG*PARTIAL~

**HCBS Waiver Liability Disclaimer Message:**
Sent when the Eligibility Benefit Information code indicates HCBS Waiver Liability (EB01 = "Y") and there is no HCBS Waiver Liability met date in the Eligibility/Benefit Date segment above.

MSG*MONTHLY
MSG*Amount is based on claims processed at the time of this eligibility verification. With the exception (POS) pharmacy claims, member is not required to pay the provider until the member receives the monthly Medicaid/HCBS Spend-down Summary Notice listing.~

**Normalized Patient Last Name Message**
MSG*Member Last Name Returned Reflects the Name Found in the IHCP System~

**Benefit Limit on Tooth Sealants**
Sent to report teeth that have already been sealed.
MSG*2,3,4,5,12,13,14,15,18,19,20,21,28,29,30,31~

<table>
<thead>
<tr>
<th>Code</th>
<th>Type</th>
<th>Message Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>323</td>
<td>2110C</td>
<td>MSG01 Free-form Message Text</td>
</tr>
<tr>
<td>344</td>
<td>2120C</td>
<td>PRV Subscriber Benefit Related Provider Information</td>
</tr>
<tr>
<td>345</td>
<td>2120C</td>
<td>PRV03 Reference Identification</td>
</tr>
<tr>
<td>347</td>
<td>2000D</td>
<td>HL Dependent Level</td>
</tr>
</tbody>
</table>

The IHCP patient is always the subscriber.
# Appendices

## 11 Implementation Checklist


## 11.2 Change Summary

This section describes the differences between the current Companion Guide and previous guide(s).

<table>
<thead>
<tr>
<th>Version</th>
<th>CO</th>
<th>CO Name</th>
<th>Revision Date</th>
<th>Revision Status</th>
<th>Revision Reason</th>
<th>Completed by</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>2403</td>
<td>Inpatient Hospital Claims for DOC Inmates</td>
<td>Dec 2014</td>
<td>Implemented</td>
<td>16, 24 – Add Department of Corrections Message</td>
<td>Systems</td>
</tr>
<tr>
<td>2.1</td>
<td>2434</td>
<td>HIP 2.0 HPE Adult</td>
<td>Feb 2015</td>
<td>Implemented</td>
<td>13, 16, 24 – HIP2.0 new Elig Indicators and Message Text</td>
<td>Systems</td>
</tr>
<tr>
<td>2.2</td>
<td>2462</td>
<td>HIP 2.0 Fast Track Credit Card</td>
<td>May 2015</td>
<td>Implemented</td>
<td>13 – EB05 Loop2110C – Added ‘HIP State Plan PLUS with COPAY’</td>
<td>Systems</td>
</tr>
<tr>
<td>2.3</td>
<td>2445</td>
<td>HCC – Hoosier Care Connect</td>
<td>May 2015</td>
<td>Implemented</td>
<td>13 – EB05 Loop2110C – Added ‘Hoosier Care Connect’ 21 – 4.2.6.4 EB05 – Added ‘Hoosier Care Connect’</td>
<td>Systems</td>
</tr>
<tr>
<td>2.4</td>
<td>AIM: 2473</td>
<td>HIP Link</td>
<td>Aug 2015</td>
<td>Implemented</td>
<td>13 – EB05 Loop2110C – Added ‘HIP LINK’ 20 – 4.2.6.2 – Added ‘HIP LINK’</td>
<td>Systems</td>
</tr>
</tbody>
</table>

### CoreMMIS Change Summary

<table>
<thead>
<tr>
<th>Version</th>
<th>DDI CO</th>
<th>CO Name</th>
<th>Revision Date</th>
<th>Revision Status</th>
<th>Revision Page Numbers / Change / Update Details</th>
<th>Completed by</th>
</tr>
</thead>
<tbody>
<tr>
<td>9538</td>
<td>45796</td>
<td>HPE Rebranding - EDI Forms</td>
<td>Mar 2016</td>
<td>Implemented</td>
<td>Throughout document - Changed Hewlett Packard (HP) to Hewlett Packard Enterprise (HPE).</td>
<td>Systems</td>
</tr>
<tr>
<td>10694</td>
<td></td>
<td>Corrections</td>
<td>Apr 2016</td>
<td>Implemented</td>
<td>Pg. 20 – Added bullet 4.2.5.3 – IHCP expects only one iteration of the functional group control segment.</td>
<td>Systems</td>
</tr>
<tr>
<td>10800</td>
<td></td>
<td>Corrections</td>
<td>June 2016</td>
<td>Implemented</td>
<td>Pg. 18 – Revised Eligibility (270) search option 4.2.2.3 to add DOB to search criteria with member SSN</td>
<td>Systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corrections</td>
<td>Sept 2016</td>
<td>Implemented</td>
<td>Pg. 18 – Removed item 4.2.3.6.2</td>
<td>Systems</td>
</tr>
<tr>
<td>Issue ID</td>
<td>Description</td>
<td>Date</td>
<td>Status</td>
<td>Notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------</td>
<td>--------</td>
<td>-------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n/a</td>
<td>Addition - State approved STC codes</td>
<td>Oct. 2016</td>
<td>Implemented</td>
<td>Health Care Benefit Inquiry (270) Pg. 8: BTH03 - removed reference to interactive transactions. Pg. 9: Health Care Benefit Inquiry (270) Loop 2110C EQ01 - added Service Type Codes 1, 2, 5, 6, 7, 8, 13, 20, 40, 45, 47, 48, 50, 51, 52, 53, 62, 65, 68, 73, 76, 78, 80, 82, 86, 88, 99, A0, A3, A6, A7, AG, BG, BH, MH, UC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.0</td>
<td></td>
<td>Dec. 2016</td>
<td>Pending</td>
<td>Indiana CoreMMIS Implementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Corrections</td>
<td>Jan. 2017</td>
<td>Pending</td>
<td>Pg 11 - Loop2100B NM102 - Removed IHCP specification of the Entity Type Qualifier will always be a '2'-IHCP considers all providers a Non-Person Entity. The CoreMMIS system will return appropriate qualifier according to the HIPAA 271 Implementation Guide. Pg 17 - 4.2.1 NPI/LPI Crosswalk - removed. The CoreMMIS system will not validate NPI crosswalk for eligibility requests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td>11834</td>
<td>April, 2017</td>
<td>Implemented</td>
<td>Pg. 15 - 16, Loop 2110C MSG01: Revised Spend-down Disclaimer Message to 264 characters, maximum allowed per segment, removed Disclaimer Message segments 2 and 3. Pg. 21, 4.2.5.8 – Revised response for Qualified Medicare Beneficiary (QMB) Throughout document – Changed Hewlett Packard Enterprise (HPE) To DXC Technology.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td></td>
<td>Sept 2017</td>
<td>Implemented</td>
<td>Pg. 11-16 Section 7 – Updated to CoreMMIS Specific Business Rules and Limitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td>Corrections CR55448 - HIP Waiver II</td>
<td>March 2018</td>
<td>Implemented</td>
<td>Pg. 11 Section 7.2 – Added NPI Crosswalk information to processing guidelines Pg. 15 Added WAIVER LIABILITY Response to Section 7.3.12. Pg. 22 – Loop 2110C EB05: Added new MA HIP Maternity Plan Coverage Description: HIP Maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>46806</td>
<td>Sept 2018</td>
<td>Implemented</td>
<td>Pg. 18 Section 7.3.20 – Added MSG=teeth sealed. Pg. 26 MSG segment – Added text for teeth sealed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>58053</td>
<td>July 2019</td>
<td>Implemented</td>
<td>Pg. 9 - Update File Exchange domain name</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>