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: 3.8
Revision Date: August 2024

Companion guide © copyright 2024 by Indiana Health Coverage Programs. All rights reserved. It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holder. This document is provided “as is” without any express or implied warranty.

Note that the copyright on the underlying ASC X12 Standards is held by DISA on behalf of ASC X12.

Preface

This companion guide to the v5010 ASC X12N implementation guides and associated errata adopted under the Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the Indiana Health Coverage Programs (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 7
1.1 SCOPE 8
1.2 OVERVIEW 8
1.2.1 OVERVIEW OF HIPAA LEGISLATION 8
1.2.2 COMPLIANCE ACCORDING TO HIPAA 8
1.2.3 COMPLIANCE ACCORDING TO ASC X12 8
1.3 REFERENCES 8
1.3.1 GOVERNMENT AND OTHER ASSOCIATIONS 8
1.3.2 ASC X12 STANDARDS 8
1.4 ADDITIONAL INFORMATION 9
1.4.1 NATIONAL PROVIDER IDENTIFIER 9
2 GETTING STARTED 9
2.1 WORKING WITH THE IHCP 9
2.2 TRADING PARTNER REGISTRATION 9
2.3 CERTIFICATION AND TESTING OVERVIEW 10
3 TESTING WITH THE PAYER 10
4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS 11
4.1 PROCESS FLOWS 11
4.2 TRANSMISSION ADMINISTRATIVE PROCEDURES 12
4.2.1 SYSTEM AVAILABILITY 12
4.2.2 TRANSMISSION FILE SIZE 12
4.2.3 FILE NAMING CONVENTION 12
4.3 COMMUNICATION PROTOCOL SPECIFICATIONS 12
4.4 PASSWORDS 12
5 CONTACT INFORMATION 13
5.1 GAINWELL EDI TECHNICAL ASSISTANCE 13
5.2 PROVIDER SERVICE 13
5.3 APPLICABLE WEBSITES/E-MAIL 13
6 CONTROL SEGMENTS/ENVELOPES 13
6.1 ISA – IEA 13
6.2 GS – GE 13
7 PAYER-SPECIFIC BUSINESS RULES AND LIMITATIONS 13
7.1 ELIGIBILITY INQUIRY (270 INBOUND) SEARCH OPTIONS 14
7.2 FILE STRUCTURE 14
7.3 ELIGIBILITY INQUIRY (270 INBOUND) PROCESSING GUIDELINES 14
7.3.1 NPI CROSSWALK VALIDATION 14
7.3.2 MISCELLANEOUS GUIDELINES 14
7.4 ELIGIBILITY RESPONSE (271 OUTBOUND) BASIC ELIGIBLITY AND BENEFIT LIMITATIONS 14
7.4.1 ELIGIBILITY 14
7.4.2 NON-COVERED ELIGIBILITY 15
7.4.3 MEMBER NOT ELIGIBLE 15
7.4.4 PRIMARY CARE PHYSICIAN 15
7.4.5 MANAGED CARE 15
7.4.6 PROVIDER RESTRICTION 16
7.4.7 THIRD PARTY LIABILITY 16
7.4.8 MEDICARE 17
7.4.9 QUALIFIED MEDICARE BENEFICIARY (QMB) 17
7.4.10 NURSING HOME / LEVEL OF CARE 18
7.4.11 PATIENT LIABILITY 18
7.4.12 WAIVER LIABILITY 19
7.4.13 DEPARTMENT OF CORRECTIONS 19
7.4.14 COINSURANCE 19
7.4.15 COPAYMENT 20
7.4.16 DEDUCTIBLE 20

7.4.17 LOW INCOME 20
7.4.18 PREGNANCY 20
7.4.19 NORMALIZING PATIENT LAST NAME 20
7.4.20 BENEFIT LIMITS 20
7.4.21 WAIVER – MRO PROGRAM AGENCY 20

8 ACKNOWLEDGEMENTS AND/OR REPORTS 21
8.1 TA1 INTERCHANGE ACKNOWLEDGMENT OUTBOUND 21
8.2 999 FUNCTIONAL ACKNOWLEDGEMENT 21

9 TRADING PARTNER AGREEMENTS 21

10 TRANSACTION SPECIFIC INFORMATION 21
10.1 005010X279A1 HEALTH CARE BENEFIT INQUIRY (270) 22
10.2 005010X279A1 HEALTH CARE BENEFIT INFORMATION (271) 24

11 APPENDICES 30
11.1 IMPLEMENTATION CHECKLIST 30
11.2 CHANGE SUMMARY 30

1 INTRODUCTION

This section describes how ASC X12N implementation guides (IGs) adopted under the Health Insurance Portability and Accountability Act (HIPAA) will be detailed with the use of a table. The tables contain a row for each segment that the Indiana Health Coverage Programs (IHCP) 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*.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			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.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by the IHCP.
			Plan Network Identification	N6		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.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		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.

1.1 SCOPE

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.

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 for Providers website (in.gov/medicaid/providers), 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

Washington Publishing Company: http://www.wpc-edi.com

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. Electronic Data Interchange (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.

1.4.1 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.

Additional information can be found on the *National Provider Identifier* page under the Provider Enrollment section of the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

2 GETTING STARTED

2.1 WORKING WITH THE IHCP

Indiana Medicaid trading partners exchange electronic health care transactions with the IHCP 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 Trading Partner Agreement (TPA), accessible from the *Electronic Data Interchange (EDI) Solutions* page, in the Business Transactions section of the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

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 IHCP Provider 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 *Provider Healthcare Portal* reference module.

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 requires that all healthcare organizations that exchange HIPAA transaction data electronically with the 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 X12 website at x12.org.

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 (accessible from the Indiana Medicaid for Providers website at in.gov/medicaid/providers) 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 *Section 2.2: Trading Partner Registration* 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@gainwelltechnologies.com or faxed to 317-488-5185.

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

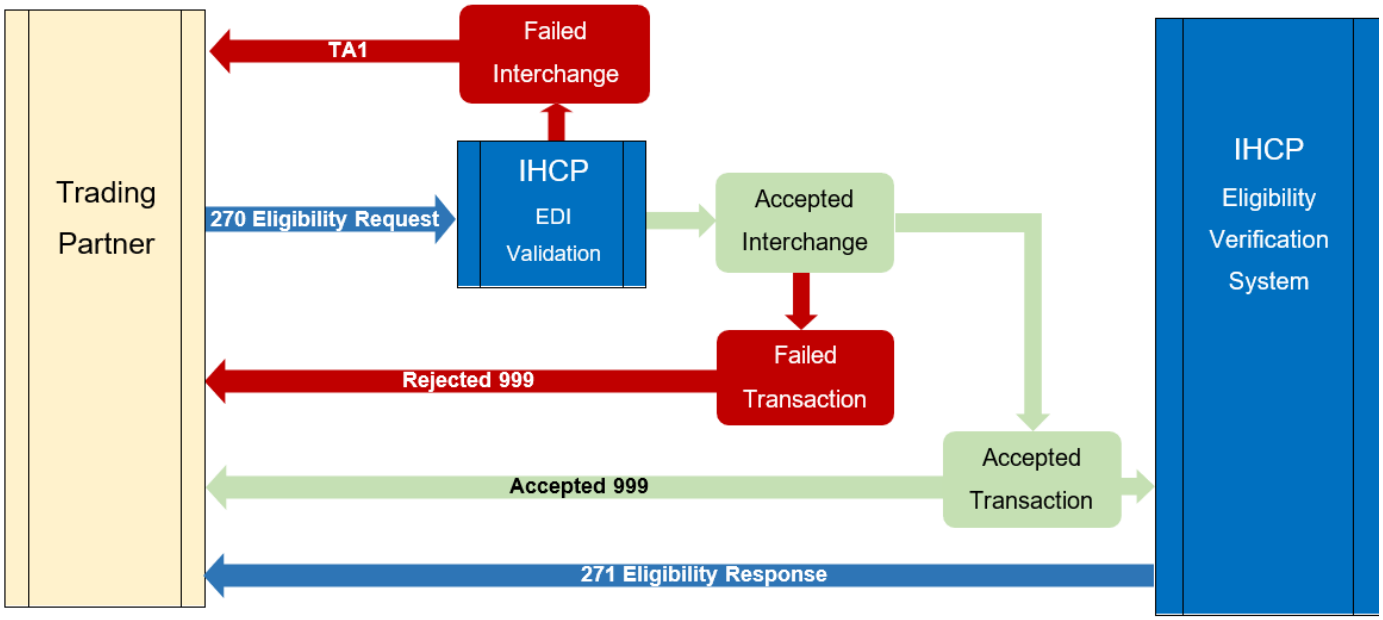
4.1 PROCESS FLOWS

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.
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* at in.gov/medicaid/providers for more information.
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.

4.2.1 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://mft.gainwelltechnologies.com/indiana-sftp in the announcements section.

4.2.2 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.

4.2.3 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. All inbound filenames should be limited to 40 bytes or less.

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 Connectivity Guide* at in.gov/medicaid/providers.

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 GAINWELL EDI TECHNICAL ASSISTANCE

PHONE: 800-457-4584
FAX: 317-488-5185
EMAIL: INXIXTradingPartner@gainwelltechnologies.com

5.2 PROVIDER SERVICE

PHONE: 800-457-4584, please listen to the entire message before making your selection.

5.3 APPLICABLE WEBSITES/E-MAIL

Indiana Medicaid for Providers website: in.gov/medicaid/providers

Trading partner information can be found in the Business Transactions section of the Indiana Medicaid for Providers website, on the *Electronic Data Interchange (EDI) Solutions* page and its subpages.

For email addresses and other contact information, see the *Contact Us* page and the *IHCP Quick Reference Guide*, available under the Contact Information section of the website.

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 "IHCP" in this companion guide refer to the Indiana Health Coverage Programs. All references to "IHCP Provider ID" in this companion guide refer to the Medicaid provider number assigned by the IHCP to a particular provider service location.

Before submitting electronic eligibility transactions to the IHCP, please review the appropriate HIPAA Technical Report Type 3 (TR3) implementation guides and IHCP companion guides. In addition, the IHCP recommends that trading partners review the IHCP provider reference modules and other resources available from the *Provider References* section of the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

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 use 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 references modules, especially *Member Eligibility and Benefit Coverage*, *Prior Authorization* and *Claim Submission and Processing*.

7.4 ELIGIBILITY RESPONSE (271 OUTBOUND) BASIC ELIGIBLITY AND BENEFIT LIMITATIONS

7.4.1 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.

7.4.2 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.

7.4.3 MEMBER NOT ELIGIBLE

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

7.4.4 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

7.4.5 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
  - Indiana PathWays for Aging 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

7.4.6 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.

7.4.7 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 or Hospital/Surgical
    - Indemnity
    - Long Term Care
    - Medical
    - Medical and Hospitalization
    - Medicare A
    - Medicare B
    - Medicare D
    - Medicare Advantage Plan
    - Medicare Supplemental Plan
    - Mental Health
    - Optical/Vision
    - Pharmacy

7.4.8 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.
  - EB01 = R – Other or Additional Payer
  - EB04 = MA – Recipient has Medicare A coverage
  - REF01 = F6 – Health Insurance Claim Number
  - REF02 = Member's Medicare Number
- ➢ Example 2 – A member has Medicare A and B coverage. Two Medicare segments are sent on the 271 transaction.
  - 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
  - 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.
  - 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
  - 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
  - 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

7.4.9 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~
```

7.4.10 NURSING HOME / LEVEL OF CARE

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 Level of Care
  - ID/DD Nursing Facility
  - ID/DD Specialized Intermediate Care in NF
  - ID/DD Specialized Skilled Care in NF
  - AIDS Intermediate Care in NF
  - AIDS Skilled Care Unit in NF
  - General Intermediate Care in AIDS NF
  - General Skilled Care in AIDS NF
  - Psychiatric Residential Treatment Facility
  - 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

7.4.11 PATIENT LIABILITY

The following values apply to patient liability other than for PathWays members:

- 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

For PathWays patient liability, an amount will not be returned. Contacting the PathWays MCE is advised.

- EB01 = U – Contact Following Entity for Eligibility or Benefit Information
- EB04 = PL – Personal
- EB05 = Test message indicating plan coverage
- DTP01 = 307 – Dates covered
- DTP02 = RD8 – CCYYMMDD format
- DTP03 = Time span covered by the date range requested
- MSG01 = Member has a Patient Liability. Contact the PathWays MCE for additional information.

7.4.12 WAIVER LIABILITY

Except for PathWays, 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
- DTP02 = RD8 – CCYYMMDD format
- DTP03 = Applicable Time Span
- MSG01 = MONTHLY

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.

Waiver liability coverage for PathWays will not return an amount, and so it will only loop once:

- EB01 = U – Contact Following Entity for Eligibility or Benefit Information
- EB05 = MEDICAID COST SHARE
- DTP01 = 307 – Applicable Date Span
- DTP02 = RD8 – CCYYMMDD format
- DTP03 = Applicable Time Span
- MSG01 = MONTHLY
- MSG01 = Member has a Waiver Liability. Contact the PathWays MCE for Liability and Prior Authorization Information

7.4.13 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

7.4.14 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

7.4.15 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

7.4.16 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
- EB06 = 25 - Contract
- EB07 = Deductible Amount
- DTP01=307, DTP02=RD8 and DTP03=deductible effective date range

7.4.17 LOW INCOME

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

7.4.18 PREGNANCY

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

7.4.19 NORMALIZING PATIENT LAST NAME

- MSG01 = Member Last Name Returned Reflects the Name Found in the IHCP System

7.4.20 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

7.4.21 WAIVER – MRO PROGRAM AGENCY

- EB01 = 1 – Active Coverage
- EB04 = MC – Medicaid
- EB05 = Medicaid Rehabilitation Option or Waiver Type
- MSG01 = Text field: PARTIAL – Partial Coverage. All programs other than Full Medicaid and Package A.
- MSG01 = Text field: Please see the IHCP Provider Manual – Please consult the manual for more information.
- MSG01 = Agency Name|Date Agency Data Received|Agency Type
- NM103 = Agency Name
- PER04 = Agency Phone Number
- PER06 = Agency Fax Number (if on file)

- PER08 = Agency Email Address (if on file)
  - Example:

```
EB*1*IND*30*MC*Medicaid Rehabilitation Option~
DTP*307*RD8*20210221-20210221~
MSG*PARTIAL~
MSG*Please see the IHCP Provider Manual~
MSG*Agency ABC|20200315|MRO~
LS*2120~
NM1*2B*2*Agency ABC~
PER*IC**TE*3175551212*FX*3175550000*EM*agencyabc@yahoo.com
LE*2120
```

8 ACKNOWLEDGEMENTS AND/OR REPORTS

8.1 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.

8.2 999 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. 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.

More information can be found in the *Electronic Data Interchange (EDI) Solutions* web page, in the Business Transactions section of the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

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)

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
63		BHT	Beginning of Hierarchical Transaction			
64		BHT03	Reference Identification			IHCP supports a maximum of 15 characters for batch transactions.
69	2100A	NM1	Information Source Name			
69	2100A	NM101	Entity Identifier Code	P5 PR		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.
70	2100A	NM103	Name Last or Organization Name			IHCP uses “Indiana Health Coverage Program”
71	2100A	NM109	Identification Code			IHCP uses “IHCP”
75	2100B	NM1	Information Receiver Name			
77	2100B	NM108	Identification Code Qualifier			IHCP expects SV to be used by atypical providers
78	2100B		Identification Code			IHCP atypical provider identifiers are 10 characters long; nine numeric and one alpha location code
82	2100B	N4	Information Receiver City, State, ZIP Code			
83	2100B	N403	Postal Code			Refer to Section 7.3.1 for NPI crosswalk processing guidelines.
84	2100B	PRV	Information Receiver Provider Information			
85	2100B	PRV03	Reference Identification			IHCP may need the taxonomy code for a successfully NPI crosswalk. Refer to Section 7.3.1 for NPI crosswalk processing guidelines.
92	2100C	NM1	Subscriber Name			
	2100C	NM108	Identification Code Qualifier	MI		IHCP only recognizes MI
96	2100C	NM109	Identification Code		12	The IHCP subscriber identification number is 12 digits.
	2100C	REF	Subscriber Additional Identification			
	2100C	REF01	Reference Identification Qualifier	F6 EJ SY		IHCP supports F6, EJ and SY
122	2100C	DTP	Subscriber Date			
123	2100C	DTP03	Date Time Period			IHCP inquires must contain dates within the same month.

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
124	2110C	EQ	Subscriber Eligibility or Benefit Inquiry			IHCP recognizes and processes up to 20 EQ segments.
125	2110C	EQ01	Service Type Code			Refer to the *Member Eligibility and Benefit Coverage* module for a description of basic eligibility and benefit limitations. Not all codes for benefit limitations are valid for every provider. 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 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 68 – 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

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
						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
146	2000D	HL	Dependent Level			The IHCP patient is always the subscriber

10.2 005010X279A1 HEALTH CARE BENEFIT INFORMATION (271)

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
213	2000A	HL	Information Source Level			
214	2000A	HL04	Hierarchical Child Code			IHCP returns a 0 when a source level error occurs in the 270 transaction. Examples of source level errors: • Unrecognized payer • Interactive quantity exceeded Also see 2100A AAA03 Reject Reason Codes
218	2100A	NM1	Information Source Name			
218	2100A	NM101	Entity Identifier Code	P5 PR		IHCP uses P5 when the member is risk-based (RBMC). IHCP uses PR when the member is non-managed care, primary care case management (PCCM), or when the delivery system is unknown.
219	2100A	NM103	Name Last or Organization Name			IHCP uses “Indiana Health Coverage Program”
220	2100A	NM109	Identification Code			IHCP uses “IHCP”
232	2100B	NM1	Information Receiver Name			
233	2100B	NM102	Entity Type Qualifier			
234	2100B	NM108	Identification Code Qualifier			IHCP uses SV for atypical providers

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
235	2100B	NM109	Identification Code			IHCP atypical provider identifiers are 10 characters long.
238	2100B	AAA	Information Receiver Request Validation			
239	2100B	AAA03	Reject Reason Code			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.
243	2000C	HL	Subscriber Level			
245	2000C	HL04	Hierarchical Child Code	0		The IHCP patient is always the subscriber, therefore 0 is always sent
249	2100C	NM1	Subscriber Name			
252	2100C	NM109	Identification Code		12	The IHCP subscriber identifier is 12 digits
262	2100C	AAA	Subscriber Request Validation			
263	2100C	AAA03	Reject Reason Code			The IHCP returns code 78 for members who are not in Medicaid (PASRR, MRT and First Steps). The program does not give eligibility for these members.
283	2100C	DTP	Subscriber Date			
284	2100C	DTP03	Date Time Period			IHCP returns the 270 transaction creation date if no subscriber date is sent on the 270 transaction
289	2110C	EB	Subscriber Eligibility or Benefit Information			The IHCP sends up to 50 EB segments
291	2110C	EB01	Eligibility or Benefit Information Code			Refer to the ELIGIBILITY RESPONSE (271 OUTBOUND) BASIC ELIGIBILITY AND BENEFIT LIMITATIONS in Section 7.4 for explanations of the usage of codes used by IHCP.
293	2110C	EB03	Service Type Code			Refer to the ELIGIBILITY RESPONSE (271 OUTBOUND) BASIC ELIGIBILITY AND BENEFIT LIMITATIONS in Section 7.4 for explanations of the usage of codes used by IHCP.
298	2110C	EB04	Insurance Type Code			Refer to the ELIGIBILITY RESPONSE (271 OUTBOUND) BASIC ELIGIBILITY AND BENEFIT LIMITATIONS in Section 7.4 for explanations of the usage of codes used by IHCP.
299	2110C	EB05	Plan Coverage Description			IHCP populates this element with any of the following: **BENEFIT PLANS** • ALL Benefit Plans – for error disposition • 590 Program • Adult Mental Health Habilitation • Aged and Disabled HCBS Waiver • Aged and Disabled HCBS Pathway Waiver • Behavioral & Primary Healthcare Coordination

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
						• Children's Mental Health Wraparound • Community Integration and Habilitation HCBS Waiver • ESO Coverage with Pregnancy Coverage • Family Planning Eligibility Program • Family Supports HCBS Waiver • Full Medicaid • HIP Plus • HIP Basic • HIP Bridge 12 months Eligibility Segments • HIP Employer Link • HIP Maternity • HIP State Plan Basic • HIP State Plan Plus • HIP State Plan Plus Copay • Medicaid Inpatient Hospital Services Only • Medicaid Rehabilitation Option • Medical Review Team • MFP Community Integration and Habilitation • MFP Demonstration Grant HCBS Waiver • MFP PRTF Transition from PRTF • MFP Transition from State Owned Facility • MFP Traumatic Brain Injury • Package A - Standard Plan • Package C - Children’s Health Plan (SCHIP) • Package E - Emergency Services Only • PASRR Mental Illness (MI) • PASRR Individuals with Intellectual Disability • Presumptive Eligibility Adult • Presumptive Eligibility Family Planning Svcs Only • Presumptive Eligibility Package A Standard Plan • Presumptive Eligibility for Pregnant Women • Program of All-Inclusive Care for the Elderly • PRTF Transition Waiver • Qualified Disabled Working Individual • Qualified Individual • Qualified Medicare Beneficiary • Specified Low Income Medicare Beneficiary • Traumatic Brain Injury HCBS Waiver **LEVEL-OF-CARE ASSIGNMENT PLANS** • AIDS Intermediate Care in NF • AIDs Skilled Care Unit in NF • General Intermediate Care in AIDS NF • General Skilled Care in AIDS NF

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
						• ID/DD Nursing Facility • ID/DD Specialized Intermediate Care in NF • ID/DD Specialized Skilled Care in NF • 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 • Nursing Facility Level of Care • Psychiatric Residential Treatment Facility **MANAGED CARE ASSIGNMENT PLANS** • Fee for Service + NEMT • Healthy Indiana Plan Managed Care • Hoosier Care Connect • Hoosier Healthwise Managed Care • Program of All-Inclusive (PACE) Managed Care • Indiana PathWays For Aging Managed Care **RIGHT CHOICES PROGRAM ASSIGNMENT PLANS** • RCP-Inpatient Hospital • RCP-Outpatient Hospital • RCP-Pharmacy • RCP-Physician **OTHER INSURANCE PLANS** • Cancer • Dental • Home Health • Hospitalization or Hospital/Surgical • Indemnity • Long Term Care • Medical • Medical and Hospitalization • Medicare A • Medicare B • Medicare D • Medicare Advantage Plan • Medicare Supplemental Plan • Mental Health • Pharmacy • Optical/Vision

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
300	2110C	EB07	Monetary Amount			Patient Liability Amount is returned here if EB01 = X and a patient liability amount applies. If EB01 = J then dental cap dollars (up to $600) or supply dollars for incontinent supplies (up to $1950) are reported here. If EB01 = MC and the Plan Coverage description indicates Healthy Indiana Plan, then this field represents the Emergency Room Copay amount. HCBS Waiver Liability amount is returned here if EB01 = Y and the amount is greater than zero.
317	2110C	DTP	Subscriber Eligibility/Benefit Date			IHCP uses this segment to report multiple Eligibility Program and Managed Care segments, if available. This segment is also used to indicate HCBS Waiver Liability. When the preceding EB01 indicates Y and this segment is not sent, HCBS Waiver Liability has not been met.
317	2110C	DTP01	Date/Time Qualifier	307		IHCP uses code 307 for Eligibility Program and Managed Care.
318	2110C	DTP03	Date Time Period			IHCP reports the dates of service used for the eligibility transaction.
322	2110C	MSG	Message Text			IHCP uses the MSG segment for the following: *Please See the IHCP Provider Manual *Partial *HCBS Waiver Liability Disclaimer *Normalized Patient Last Name *Waiver – MRO Program Agency (agency name | date agency data received | agency type
323	2110C	MSG01	Free-form Message Text			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.~

PAGE #	LOOP ID	REFERENCE	NAME	CODES	LENGTH	NOTES/COMMENTS
						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~ **Waiver – MRO Program Agency** Sent to report agency name, data received date and agency type separated by pipe delimiter. MSG*Agency ABC|20210115|MRO~ **Patient Liability – PathWays** Sent to point submitter to MCE for liability information. MSG*Member has a Patient Liability. Contact the Pathways MCE for additional information.~ **Waiver – PathWays** Sent to point submitter to MCE for liability information. MSG*Member has a Waiver Liability. Contact the PathWays MCE for Liability and Prior Authorization Information.~
344	2120C	PRV	Subscriber Benefit Related Provider Information			
345	2120C	PRV03	Reference Identification			IHCP uses this element to identify the IHCP provider number of the provider to whom the member is restricted
347	2000D	HL	Dependent Level			The IHCP patient is always the subscriber

11 APPENDICES

11.1 IMPLEMENTATION CHECKLIST

See trading partner information linked from the *Electronic Data Interchange (EDI) Solutions* webpage, on the Indiana Medicaid for Providers website at in.gov/medicaid/providers.

11.2 CHANGE SUMMARY

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

Version	CO	CO Name	Revision Date	Revision Status	Revision Reason	Completed by
2.0			Dec 2012	Implemented	CAQH CORE format	Systems
2.1	2403	Inpatient Hospital Claims for DOC Inmates	Dec 2014	Implemented	Pg. 16, 24 – Added Department of Corrections Message	Systems
2.1	2434	HIP 2.0 HPE Adult	Feb 2015	Implemented	Pg. 13, 16, 24 – HIP2.0 new Elig Indicators and Message Text	Systems
2.2	2462	HIP 2.0 Fast Track Credit Card	May 2015	Implemented	Pg. 13 – EB05 Loop2110C: Added 'HIP State Plan PLUS with COPAY'	Systems
2.3	2445	HCC – Hoosier Care Connect	May 2015	Implemented	Pg. 13 – EB05 Loop2110C: Added 'Hoosier Care Connect' Pg. 21 – 4.2.6.4 EB05: Added 'Hoosier Care Connect'	Systems
2.4	AIM: 2473	HIP Link	Aug 2015	Implemented	Pg. 3 – EB05 Loop2110C: Added 'HIP LINK' Pg. 20 – 4.2.6.2: Added 'HIP LINK'	Systems

*Core*MMIS Change Summary

Version	DDI CO	CO Name	Revision Date	Revision Status	Revision Page Numbers / Change / Update Details	Completed by
	9538	45796 – HPE Rebranding – EDI Forms	Mar 2016	Implemented	Throughout document – Changed Hewlett Packard (HP) to Hewlett Packard Enterprise (HPE).	Systems
	10694	Corrections	Apr 2016	Implemented	Pg. 20 – Added bullet 4.2.5.3: IHCP expects only one iteration of the functional group control segment.	Systems
	10800	Corrections	Jun 2016	Implemented	Pg. 18 – Revised Eligibility (270) search option 4.2.2.3 to add DOB to search criteria with member SSN	Systems
		Corrections	Sep 2016	Implemented	Pg. 18 – Removed item 4.2.3.6.2 Pg. 19 – Added segment NM103 to Member name search option	Systems
	n/a	Addition - State approved STC codes	Oct 2016	Implemented	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	Systems

Version	DDI CO	CO Name	Revision Date	Revision Status	Revision Page Numbers / Change / Update Details	Completed by
	12226	CR 50001-H7 834 and 270/271 Companion Guide Updates	Dec 2016	Implemented	Pg. 17 and 25 – Revised Coinsurance/Copayment Message to “Applicable dollar amount”	
3.0			Dec 2016	Implemented	Indiana *Core*MMIS Implementation	Systems
3.1		Corrections	Jan 2017	Implemented	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 *Core*MMIS system will return appropriate qualifier according to the HIPAA 271 Implementation Guide. Pg. 17 – 4.2.1: Removed NPI/LPI Crosswalk. The *Core*MMIS system will not validate NPI crosswalk for eligibility requests.	Systems
3.2	11834	Waiver Liability information not correctly sent on 271 xml Corrections	Apr 2017	Implemented	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	Systems
3.3			Sep 2017	Implemented	Pg. 11-16 – Section 7: Updated to *Core*MMIS Specific Business Rules and Limitations	Systems
3.4		Corrections CR55448 - HIP Waiver II	Mar 2018	Implemented	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	Systems
3.5	46806	Tooth Sealant Limitations	Sep 2018		Pg. 18 – Section 7.3.20: Added MSG=teeth sealed. Pg. 26 – MSG segment: Added text for teeth sealed	Systems
3.5	58053	File Exchange Domain Name Change	Jul 2019		Pg. 9 – Updated File Exchange domain name	Systems
3.6	GT-2185	Case Manager Visibility	May 2021	Implemented	Pg. 20, Section 7.4.21: Waiver – Updated MRO Program Agency information Pg. 25, Section 10.2 – Added benefit plan: ESO Coverage with Pregnancy Coverage Pg. 27 – Loop 2110C – MSG01 – Message Text: Added text for Waiver – MRO Program Agency Updated DXC to Gainwell	Systems
3.7		Update to Benefit Plan List		Implemented	Pg. 26, Section 10.2 – Updated benefit plans to include Package B – Emergency Services Only with Pregnancy Coverage Updated the email address for trading partner agreements and EDI technical assistance	Systems

Version	DDI CO	CO Name	Revision Date	Revision Status	Revision Page Numbers / Change / Update Details	Completed by
3.8	CO 12402	GT 12402 834 MCE Benefit Enrollment & Maintenance	Jul 2024	Implemented	Updated the following sections to include information for the Indiana PathWays for Aging managed care plan and associated PathWays waiver plan: Pg. 15, Section 7.4.5: Managed Care Pg. 18, Section 7.4.11: Patient Liability Pg. 19, Section 7.4.12: Waiver Liability Pg. 25 and 27, Section 10.2, Loop 2110C, EB05 – Benefit Plans Pg. 28, Section 10.2, Loop 2110C, MSG01 – Patient Liability and Waiver	Systems
		General Updates / Correction	Aug 2024	Implemented	Pg. 10, Section 2.3 – Updated the website for obtaining IGs Pg. 12, Section 4.2.1 – Updated the URL for the MOVEit File Exchange server Pg. 26, Section 10.2 – Removed duplicate benefit plan: Package B – Emergency Services Only with Pregnancy Coverage	