COLORADO
Department of Health Care Policy & Financing

gainwell

Colorado Medical Assistance Program

Health Care Eligibility Benefit Inquiry and Response (270/271) Transaction Standard Companion Guide

Companion to Health Care Eligibility Benefit Inquiry and Response ASC X12N 270/271 005010X279 Implementation Guide

March 2024

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Preface

This companion guide to the Health Care Eligibility Benefit Inquiry and Response (270/271) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the Department of Health Care Policy & Financing (the Department). Transmissions based on this companion guide, used in tandem with the **ASC X12N/005010X279 Implementation Guide and the associated addendum 005010X279A1** 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.

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1. INTRODUCTION

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 healthcare transactions primarily between healthcare 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

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into transition 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 specification or are not in the standard’s implementation specifications
- Change the meaning or intent of the standards implementation specifications

SCOPE

The companion guide is to be used with, and to supplement the requirements in the HIPAA Accredited Standards Committee (ASC) X12 implementation guides, without contradicting those requirements. Implementation guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the companion guide is to provide trading partners with a guide to communicate information specific to the Colorado Medical Assistance Program that is required to successfully exchange transactions.

The companion guide is intended for the business and technical users, within or on behalf of trading partners, responsible for the testing and setup of electronic claim status request and response transactions to the fiscal agent on behalf of the Department.

OVERVIEW

This section of the companion guide will provide guidance for establishing a relationship with the Department for the business purpose of submitting Health Care Eligibility Benefit Inquiry and Response (270/271).

REFERENCES

This section specifies additional on-line sources of helpful information related to electronic data interchange (EDI) and X12 transactions.

Workgroup for Electronic Data Interchange (WEDI) – https://www.wedi.org/
United States Department of Health and Human Services (HHS) – https://aspe.hhs.gov/
Centers for Medicare and Medicaid Services (CMS) – https://www.cms.gov/
Designated Standard Maintenance Organizations (DSMO) – https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/StandardsSettingandRelatedOrganizations
National Council of Prescription Drug Programs (NCPDP) – https://www.ncpdp.org/
National Uniform Billing Committee (NUBC) – https://www.nubc.org/
Accredited Standards Committee (ASC X12) – https://x12.org/
Washington Publishing Company (WPC) – https://wpc-edi.com/

Affordable Care Act (ACA) Section 1104 information is at the Centers for Medicare & Medicaid Services (CMS) website. Visit https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/StandardsSettingandRelatedOrganizations for information on ACA Administrative Simplification information.

ADDITIONAL INFORMATION

It is assumed that the trading partner has purchased and is familiar with the ASC X12 Type 3 Technical Report (TR3) being referenced in this companion guide. TR3s can be purchased from the ASC X12 store at https://x12.org/products.

2. GETTING STARTED

TRADING PARTNER REGISTRATION

Any entity intending to exchange electronic transactions with the Department must agree to the Trading Partner Agreement at the end of the trading partner profile process. A trading partner profile can be completed using the Provider Web Portal at https://colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/provider/Home/tabid/135/Default.aspx.

Note: Providers must be enrolled and approved before registering as a trading partner.

The Web Portal and the Secure File Transfer Protocol (SFTP) will include the ability for file and report retrieval. Billing agents and clearinghouses will have the option of retrieving the transaction responses and reports themselves and/or allowing each individual provider the option of retrieval. The trading partner will access the system using the assigned login and password. Visit https://colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/provider/Home/tabid/135/Default.aspx for information on the Web Portal.

CERTIFICATION AND TESTING OVERVIEW

All covered entities who submit electronic transactions are required to certify. This includes clearinghouses, software vendors, provider groups, and managed care organizations (MCOs). If submitting electronic transactions through one of these agencies, the agency will certify on behalf of the covered entity. Otherwise, the covered entity will need to certify. If submitting electronic transactions through an MCO, information should be received from the MCO with certification requirements.

Results of the system's processing of electronic transactions are reviewed and communicated back via email. Once the test files all pass, a production ID and welcome letter will be sent confirming certification.

3. TESTING WITH THE PAYER

This section contains a detailed description of the testing phase.

Testing is required for the Health Care Claims Status Request and Response (270/271).

Before exchanging production transactions with the Department, each trading partner must complete production authorization testing.

Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

Trading partners are encouraged to submit ten successful and unique submissions and receive the associated 999 (accepted) acknowledgement in response in order to obtain approval to promote to production.

Trading partner authorization testing is detailed in the Trading Partner Testing Packet for ASC X12 transactions available on the Colorado Electronic Data Interchange (EDI) Support page at https://hcpf.colorado.gov/edi-support.

Questions may be directed to the Provider Services Call Center, or via the Contact Us link at the top of the Provider Web Portal home page at https://colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/provider/Home/tabid/135/Default.aspx.

4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

PASSWORDS

Passwords are provided during initial enrollment and can be reset by contacting the Provider Services Call Center. These passwords may not be shared.

https://hcpf.colorado.gov/edi-support

5. CONTACT INFORMATION

WORKING WITH THE DEPARTMENT

To assist the community with their electronic data exchange needs, the following options are available for either contacting a help desk or referencing a website for further assistance:

Visit the Department's website at https://hcpf.colorado.gov/edi-support for general information.

ELECTRONIC DATA INTERCHANGE (EDI) SERVICES

Contact the Provider Services Call Center with any questions.

6. CONTROL SEGMENTS/ENVELOPES

ISA-IEA

This section describes the use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters. (See Section 9 Transaction-Specific Information below.)

GS-GE

This section describes the use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how the Department expects functional groups to be sent and how the Health Care Eligibility Benefit Inquiry and Response (270/271) Transaction Standard Companion Guide will send functional groups. These discussions will describe how similar transaction sets will be packaged and the use of functional group control numbers. (See Section 9 Transaction-Specific Information below.)

ST-SE

This section describes the use of transaction set control numbers. (See Section 9 Transaction-Specific Information below.)

7. ACKNOWLEDGEMENTS AND/OR REPORTS

No acknowledgements are expected for the 270/271 transactions.

8. TRADING PARTNER AGREEMENTS

An Electronic Data Interchange (EDI) trading partner is defined as any customer of the Department (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from the fiscal agent on behalf of the Department.

Payers have EDI Trading Partner Agreements (TPAs) that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

9. 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 contains additional information not found 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 Department

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

All members of the Department are considered “subscribers,” so they all have individual loops. See the implementation guide for additional information. Dependent loops for eligibility transactions will not be processed.

The Trading Partner ID (TPID) is the number that is assigned to the provider/submitter to uniquely identify their electronic transaction. This may also be referred to as the ECS number or TPID.

To ensure timely processing, all trading partners submitting 270 requests should have no more than 9,999 requests per envelope.

Health Care Eligibility Benefit Inquiry (270)

Loop ID	Reference	Name	Codes	Notes/Comments
HEADER	**ISA**	**Interchange Control Header**		**The ISA is a fixed-length record with fixed-length elements.** **All inbound files are constrained to a single ISA segment for tracking and balancing.** **Note: Deviating from the standard ISA element sizes will cause the Interchange to be rejected.**
	ISA01	Authorization Information Qualifier	00	
	ISA02	Authorization Information		No data is expected in this data element
	ISA03	Security Information Qualifier	00	
	ISA04	Security Information		No data is expected in this data element
	ISA05	Interchange ID Qualifier	ZZ	
	ISA06	Interchange Sender ID		Enter the TPID assigned by the Colorado Medical Assistance Program
	ISA07	Interchange ID Qualifier	ZZ	
	ISA08	Interchange Receiver ID	COMEDASSIST PROG	
	GS	**Functional Group Header**		
	GS02	Application Sender's Code		Enter the TPID assigned by the Colorado Medical Assistance Program
	GS03	Application Receiver's Code	COMEDASSIST PROG	
	GS08	Version/Release/ Industry Identifier Code	005010X279A1	Standards Approved for Publication by ASC X12 Procedures Review Board
	ST	**Transaction Set Header**		
	ST03	Version, Release, or Industry Identifier	005010X279A1	
2100A	**NM1**	**Information Source Name**		
	NM101	Entity Identifier Code	PR	
	NM102	Entity Type Qualifier	2	

Loop ID	Reference	Name	Codes	Notes/Comments
	NM103	Information Source Last or Organization Name	COLORADO MEDICAL ASSISTANCE PROGRAM	
	NM108	Identification Code Qualifier	PI	
	NM109	Information Source Primary Identifier	CO_TXIX or CO_BHA	
2100B	**NM1**	**Information Receiver Name**		
	NM108	Identification Code Qualifier	SV, XX	For Non-Healthcare Providers (Non-Covered Entities), enter the following value: SV For Healthcare Providers (Covered Entities), enter the following value: XX
	NM109	Information Receiver Identification Number		For Non-Healthcare Providers (Non-Covered Entities), enter the following value: Enter the Colorado Medical Assistance Program Provider ID assigned For Healthcare Providers (Covered Entities), enter the following value: Enter the National Provider ID
	PRV	**Information Receiver Provider Information**		Colorado Medical Assistance Program requires this segment for Provider identification.
2100C	**NM1**	**Subscriber Name**		Medicaid Subscriber is always the patient
	NM108	Identification Code Qualifier	MI	
	NM109	Subscriber Primary Identifier		Enter the Colorado Medical Assistance Program Client ID number

Health Care Eligibility Benefit Response (271)

Loop ID	Reference	Name	Codes	Notes/Comments
HEADER	**ISA**	**Interchange Control Header**		**The ISA is a fixed-length record with fixed-length elements.** **Note: Deviating from the standard ISA element sizes will cause the Interchange to be rejected.**
	ISA06	Interchange Sender ID	COMEDASSIST PROG	
	ISA08	Interchange Receiver ID		The TPID assigned by the Colorado Medical Assistance Program
	ISA11	Repetition Separator	^	Caret
	ISA16	Component Element Separator	:	Colon
	GS	**Functional Group Header**		
	GS02	Application Sender's Code	COMEDASSIST PROG	
	GS03	Application Receiver's Code		The TPID assigned by the Colorado Medical Assistance Program
	GS08	Version/Release/ Industry Identifier Code	005010X279A1	Standards Approved for Publication by ASC X12 Procedures Review Board
	ST	**Transaction Set Header**		
	ST03	Version, Release, or Industry Identifier	005010X279A1	
2100C	**NM1**	**Subscriber Name**		Eligibility Data is always presented in the Subscriber loop.
2110C	**EB**	**Subscriber Eligibility or Benefit Information**		

Loop ID	Reference	Name	Codes	Notes/Comments
	EB01	Eligibility or Benefit Information	1, 6, B, D, I, L, MC, N, R, U, X	Colorado Medical Assistance Program will return one of the following Eligibility or Benefit Information Codes: 1 6 - Used if a member record was found based on the search criteria used, but is not eligible for the date(s) requested B D I L MC N R - Used for Medicare A and/or Medicare B U - Used for TPL X
	EB05	Plan Coverage Description		If a member is determined presumptively eligible for the Colorado Medical Assistance Program, they will have a value of K1 or K5 concatenated to the end of the value in this element. When this occurs, the member is ***not*** eligible to receive Inpatient Hospital services regardless of Service Type 47 and/or 48 appearing in EB03. If a member is determined presumptively eligible for the Child Health Plan *Plus* (CHP+) program, they will have a value of K2 or K7 concatenated to the end of the value in this element. When this occurs, the member is ***not*** eligible to receive Dental services regardless of Service Type 35 and/or 36 appearing in EB03.

Loop ID	Reference	Name	Codes	Notes/Comments
	EB07	Benefit Amount		If a member has met the copay maximum amount or if copay is not required, the amount of '0' will be returned. If a member has a copay due, the copay amount returned will be the standard amount that is required for the service type code(s) returned in EB03. Refer to the MSG segment for guidance on the member's copay status.
	REF	**Subscriber Additional Identification**		
	REF02	Subscriber Eligibility or Benefit Identifier		Effective starting on October 4, 2018, for the CMS Transition Period, if a member is enrolled with Medicare and their active Medicare ID is a HIC number, then the HIC number will continue to be sent qualified as F6. If a member is enrolled with Medicare and their active Medicare ID is an MBI, then the MBI will be sent qualified as 1W. Effective starting on January 1, 2020, after the CMS Transition Period has ended, if a member is enrolled with Medicare and their active Medicare ID is a HIC number, then the HIC number will no longer be sent. If a member is enrolled with Medicare and their active Medicare ID is a MBI, then the MBI will continue to be sent qualified as 1W.
	MSG	**Message Text**		

Loop ID	Reference	Name	Codes	Notes/Comments
	MSG01	Free Form Message Text		**Note**: If more than one of these qualifier/value combinations is included in the MSG segment, they will be concatenated with a | (pipe) as the delimiter). **Example**: MCSTARTRSN$05 - System Assigned - ACC BIDM Attribution\|MCD99999999 MCD$XXXXXXXX – The related entity's Colorado Medical Assistance Program ID will be sent in this format when the related entity's NPI is sent in 2120C/NM109. COPAYSTATUS$COPAYDUE – This is sent when the member has a copay due. COPAYSTATUS$COPAYEXEMPT – This is sent when the member is exempt from copay. COPAYSTATUS$COPAYMAXMET – This is sent when the member's maximum copay has been met. MCSTARTRSN$XX – The 2-digit MC Start Reason Code related to the date span requested in the eligibility request. - The MC Start Reason Description related to the date span requested in the eligibility request.

APPENDIX 1: Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to Colorado Medical Assistance Program and its providers.

Q1: How soon should I expect to receive a 271 health care eligibility response to my submitted 270 transactions?

A1: Typically, trading partners will receive the 271 response file within 30 minutes or less of sending the 270 inquiry file. However, due to system volume, it may take up to 2 hours to receive a response.

Q2: How many 270 inquiry transaction files can I send at one time?

A2: See the Transaction Specific Information section or refer to the 270/271 Addendum that was signed at the time of the agreement.

Q3: Can I send 270 inquiry transactions to Colorado Medical Assistance Program without selecting the transaction on my Trading Partner Agreement?

A3: No. All trading partners must have signed a Trading Partner Agreement and a 270/271 Addendum and be set up for the transaction types agreed upon.

APPENDIX 2: Change Summary

Date	Change	Responsible Party
March 2017	Original Document	EDI Department
3/9/2017	EB01 - Codes and Verbiage added/removed.	Corey Wong, Celeste Coleman Ziegler
3/31/2017	Add New EDI Services Telephone Number	EDI Helpdesk
8/1/2017	Rebranding to DXC Technology	DXC, formerly HPE
2/23/2018	Updated the notes/comments for 270/Header/ISA, links in the various sections, and verbiage in the Certification and Testing Overview section.	EDI Department
7/25/2018	Updated the Loop for the EB segment and inserted the 2110C/REF segment for guidance on the CMS Transition Period.	EDI Department
11/8/2018	Updated verbiage in the Transaction Specific Information section	EDI Department
6/26/2019	Updated verbiage in the Testing With The Payer section. Inserted the 2110C/MSG segment for guidance on the MCD and copay status that be sent effective 6/27/19. Updated the notes/comments for 2110C/EB05 & 2110C/EB07.	EDI Department
10/3/2019	Updated the notes/comments for 2110C/REF02	EDI Department
10/26/2022	Rebranded from DXC to Gainwell Technologies, updated links and basic clean-up	Gainwell Technologies, formerly DXC
3/2/2023	Added BHA payer information; updated Provider Web Portal links	Gainwell Technologies
3/6/2024	Updated MSG Notes/Comments to add verbiage for Managed Care Start Reason and Description	EDI Department