COLORADO
Department of Health Care Policy & Financing

gainwell

Colorado Medical Assistance Program

Benefit Enrollment and Maintenance (834) Transaction Standard Companion Guide

Companion to Benefit Enrollment and Maintenance ASC X12N 834 005010X220 Implementation Guide

March 2025

Disclosure Statement

Preface

This companion guide to the Benefit Enrollment and Maintenance (834) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with Colorado Medical Assistance Transmissions based on this companion guide, used in tandem with the **ASC X12N 834 005010X220 Implementation Guide and the associated addendum 005010X220A1**, 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

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

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into transaction 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 Colorado Medical Assistance.

OVERVIEW

This section of the companion guide will provide guidance for establishing a relationship for the business purpose of exchanging the Benefit Enrollment and Maintenance (834) transaction.

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.

2. GETTING STARTED

TRADING PARTNER REGISTRATION

Any entity intending to exchange electronic transactions 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.

The Provider 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 their assigned login and password. Refer to the File Delivery and Retrieval System Vendor Interface Specifications on the Electronic Data Interchange (EDI) Support web page for more information.

3. TESTING WITH THE PAYER

Testing of outbound 834 files is not required.

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.

4. CONTACT INFORMATION

Visit the Colorado Department of Health Care Policy & Financing's website for general information.

ELECTRONIC DATA INTERCHANGE (EDI) SERVICES

Contact the Provider Services Call Center with any questions.

5. 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 Colorado Medical Assistance expects functional groups to be sent and how Colorado Medical Assistance 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 8 Transaction-Specific Information below.)

ST-SE

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

6. ACKNOWLEDGEMENTS AND/OR REPORTS

No acknowledgements are expected for the 834 transactions.

7. TRADING PARTNER AGREEMENTS

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

Payers have EDI Trading Partner Agreements (TPA) 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.

8. 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 Colorado Medical Assistance

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 clients of Colorado Medical Assistance are considered “subscribers,” so they all have individual loops. See the implementation guide for additional information.

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 Electronic Claim Submission (ECS) number or TPID.

Order of processing 834 files as follows:

- Full file audit (Monthly)
- Update file (Daily) produced during the full file audit cycle

Termination records are used to communicate both normal termination of enrollment as well as terminations due to setting an enrollment status to Inactive. Managed Care entities need to verify the Inactive indicator (in 2300/HD/04) to validate how to interpret the data for downstream processes.

Benefit Enrollment and Maintenance (834)

Loop ID	Reference	Name	Codes	Notes/Comments
HEADER	**ISA**	**Interchange Control Header**		**The ISA is a fixed-length record with fixed-length elements.**
	ISA06	Interchange Sender ID	COMEDASSIST PROG	
	ISA08	Interchange Receiver ID		The Trading Partner ID (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 Trading Partner ID (TPID) assigned by the Colorado Medical Assistance Program
	GS08	Version/Release/ Industry Identifier Code	005010X220A1	Standards approved for publication by ASC X12 Procedures Review Board.
	ST	**Transaction Set Header**		
	ST03	Version, Release, or Industry Identifier	005010X220A1	
	BGN	**Beginning Segment**		
	BGN01	Transaction Set Purpose Code	00, 15	Colorado Medical Assistance Program will use one of the following codes: 00 or 15
	BGN06	Original Transaction Set Reference Number		First three (3) characters will be a three (3)-digit mask starting with 101. Example: 101of5 First file of five (5) total files Files are split at the 2000 Member level detail loop. When 100,000 Member level detail loops are encountered, a new split file will be generated.
	BGN08	Action Code	2, 4	Colorado Medical Assistance Program will use one of the following codes: 2 or 4.
	REF	**Transaction Set Policy Number**		
	REF02	Master Policy Number		Pay to Provider ID
1000A	**N1**	**Sponsor Name**		

Loop ID	Reference	Name	Codes	Notes/Comments
	N102	Plan Sponsor Name	CO Medicaid, CHP+	Colorado Medical Assistance Program will use one of the following codes: "CO Medicaid" for Medicaid clients "CHP+" for CHP+ clients
	N104	Sponsor Identifier	81-1725341	Colorado Medical Assistance Program Tax ID
1000B	**N1**	**Payer**		
		N104	Insurer Identification Code	
2000	**DTP**	**Member Level Dates**		
	DTP03	Status Information Effective Date		Dates that are qualified as 473 and 474 are specific to the program aid code eligibility span. If an end date is not specified it should be assumed that it is open ended (12/31/2299). If Medicare is indicated in 2000/INS/06-1, the respective dates will be reported in this segment. If a member has both Medicare Part A and Medicare Part B, the associated dates will be presented respectively.
2100A	**NM1**	**Member Name**		
	NM109	Member Identifier		In the case where no SSN is available, receive 000000000.
2100A	**LUI**	**Member Language**		If the Written or Spoken language changes, it will not be reflected until the next full file audit. If the language changed from English to another language, the segment will be displayed in the next full file audit. If the language changed from another language to English, the segment will not be displayed in the next full file audit.
2100G	**NM1**	**Responsible Person**		
	NM101	Entity Identifier Code	QD	
2300	**HD**	**Health Coverage**		
	HD04	Plan Coverage Description		- Generic Poverty Level Code (2 bytes) - ACC Weight Value (6 bytes) - Pregnancy End Date (8

Loop ID	Reference	Name	Codes	Notes/Comments
				bytes in CCYYMMDD format) - Level of Care Code (2 bytes) - POI Indicator (1 byte) - Parent Indicator (1 byte) - Pregnant Indicator (1 byte) - Postpartum Indicator (1 byte) - ACP Indicator (1 byte) - Immigration Verification Indicator (1 byte) - Disability Indicator (1 byte) - Rate Cell Name (5 bytes) - MCD ID (10 bytes) - Inactive Indicator (1 byte) - Enrollment Start Reason Code (2 bytes – See Appendix 2) - Enrollment Stop Reason Code (2 bytes – See Appendix 2) - Cover All Coloradans Indicator (2 bytes) Changes to any of the above data elements (except Rate Cell Name) will trigger a Change record. Updates to the Rate Cell Name will be reported in the next full file audit transaction.
2300	**DTP**	**Health Coverage Dates**		
	DTP03	Coverage Period		The dates reported in this segment are specific to the actual managed care enrollment span. These could also include retroactive or future dated enrollment regardless of timeframe. Enrollments that are generated or terminated will be reported in the next scheduled file regardless of the enrollment dates.
	AMT	**Health Coverage Policy**		In the full file audit transaction and when reporting adds or reinstatement records in the Update transaction, the calculated co-pay maximum for the month will be reported. If the household meets the co-

Loop ID	Reference	Name	Codes	Notes/Comments
				pay maximum at any point in the given month, a change record in the Update transaction will be generated indicating the co-pay maximum has been reset to zero (0) for the remainder of that month.
2320	**COB**	**Coordination of Benefits**		If a client has >5 TPL spans, only the five (5) most current spans will be used.

APPENDIX 1: Enrollment Reason Code Definitions

ID	Description	Start/Stop/Both
01	Client Requested	Both
02	BH RAE Override	Both
03	System attribution - Used to identify when the system attributes through the iC default portion of the Auto- Assignment process which includes geographical attribution	Both
04	Manual – Lock In	Both
05	System Assigned - ACC BIDM Attribution	Start Only
06	System Assigned - BIDM Re-Attribution	Both
07	Mental Health Institute	Both
08	System Assigned - Newborn Auto-Assignment	Start Only
09	Enrollment Broker	Start Only
10	Enrollment Broker	Stop Only
11	Manual - Department Requested	Both
12	Enrollment Broker – Department Requested	Both
13	Manual - Department Initiated	Both
14	CHP+ Opt-Out – Informational Only, no functionality	Stop Only
15	Client Deceased	Stop Only
16	PCMP does not accept Client's age	Stop Only
52	System Assigned – Auto Assigned Members of same case	Start Only
54	System Assigned - Even Distribution	Start Only
55	System Assigned – Previous PMP historical assignment	Start Only
57	System Assigned - Mass Transfer	Both
81	System Assigned - Eligibility Ended	Stop Only
97	System Assigned - Conversion	Start Only
98	System Assigned – Conversion	Stop Only
99	System Assigned - Assignment is added/date is open ended	Both
OO	Manual – Opt Out	Stop Only
OC	Manual – CHP+ Opt Out	Stop Only
PM	System Assigned – PACE assignment by mailing address	Start Only
PR	System Assigned – PACE assignment by residential address	Start Only
PS	Manual – PACE end dated by user	Stop Only
ZZ	System Assigned – Mass disenrollment	Stop Only

APPENDIX 2: Change Summary

Date	Change	Responsible Party
March 2017	Original Document	EDI Department
3/31/2017	Added New EDI Service Telephone Number.	EDI Helpdesk
8/1/2017	Rebranding to DXC Technology	DXC, formerly HPE
4/2/2018	Updated the notes/comments for: 2000/REF, 2000/DTP/03, 2100A/LUI, 2300/HD/04, 2300/DTP/03, 2300/AMT; links in the various sections; and verbiage in the Certification and Testing Overview & Transaction- Specific Information sections. Added notes/comments for new data element BGN06.	EDI Department
7/25/2018	Updated the notes/comments for 2000/REF to add guidance on the CMS Transition Period.	EDI Department
10/3/2019	Updated verbiage in sections 3, 4, and 5. Updated the notes/comments for 2000/REF and 2300/HD04. Added Appendix 2.	EDI Department
5/24/2022	Updating hyperlinks, rebranding to Gainwell Technologies	EDI Department
6/7/2022	Updated Appendix 2	Managed Care/EDI
6/9/2022	Notes and comments update for 2300/HD04	Managed Care
10/26/2022	Added CO and Gainwell branding, updated links and general cleanup	Gainwell Technologies
3/28/2023	Updated Provider Web Portal links	Gainwell Technologies
11/15/2024	Notes/Comments update for 2300/HD04 – Cover All Coloradans	Gainwell Technologies
03/19/2025	Various updates to remove outdated information and confirm existing information	Gainwell Technologies