



Batch and Interactive Health Care Eligibility and Response Transaction Companion Guide

Version 1.9

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Connecticut Medicaid Assistance Program

Disclaimer: The information contained in this companion guide is subject to change.

Disclosure Statement

The Agency for Health Care Administration (AHCA) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. This document is intended to serve as a companion guide to the corresponding ASC X12N/005010X279 Health Care Eligibility/Benefit Inquiry and Information Response (270/271), its related addenda (005010X279A1), and its related errata (005010X279E1).

Disclosure of Medicaid Beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Provider Medicaid Beneficiary eligibility transaction is to be used for conducting Medicaid business only.

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Preface

This companion guide to the 005010 ASC X12N Implementation Guide and associated errata and addenda adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Connecticut Medical Assistance Program. Transmissions based on this companion guide, used in tandem with the 005010 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. The ASC X12 TR3s that detail the full requirements for these transactions are available at <http://store.x12.org/store/>.

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1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA), which was passed in 1996, requires all insurance carriers and payers in the United States to comply with a set of standards adopted by the Secretary of Health and Human Services. These standards were created to assure an efficient and secure exchange of electronic health information.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) (referred to as Health Care Eligibility Transaction in the rest of this document) for the purpose of submitting eligibility and benefit inquiries electronically. This companion guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide trading partners with a guide to communicate Connecticut Medical Assistance Program specific information required to successfully exchange transactions electronically with the Connecticut Medical Assistance Program. 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 Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

1.2 Overview

This companion guide has been created to assist in designing Health Care Eligibility transactions to conform to implementation standards and Connecticut Medical Assistance Program's processing rules. This guide should be used to supplement the instructions pertaining to the Health Care Eligibility Benefit Inquiry and Response (270/271) as stated by the X12 Standards for Electronic Data, Addenda A1 (V. 005010X279A1).

This document is subject to change as new information is available. Please check the Connecticut Medical Assistance Program Web site at www.ctdssmap.com regularly for updated information.

1.3 References

Washington Publishing Company (WPC) – <http://www.wpc-edi.com> – WPC maintains and publishes the X12N Implementation Guides containing the standards for electronic health care transactions.

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's information technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files

with the Connecticut Medical Assistance Program.

Electronic submitters should use the Implementation Guides and Companion Guide for format and code set information. In addition to the Implementation Guide and the Companion Guide, electronic submitters should use Chapter 8 of the Provider Manual for specific Connecticut Medical Assistance Program claim submission instructions and policy guidelines. Chapter 8 can be found at the following link:

<https://www.ctdssmap.com/CTPortal/Information/Publications/tabid/40/Default.aspx>

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 X12 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 document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

The 270/271 is a paired transaction set used to send and receive eligibility verification requests and responses. The following companion document provides data clarification for the 270/271 Health Care Eligibility Benefit Inquiry and Response (005010X279A1) transaction.

Three Digit Carrier Codes are used by the Connecticut Medical Assistance Program to identify other payers. A listing of these codes can be found at the following link under Additional Chapter 5 Information:

<https://www.ctdssmap.com/CTPortal/Information/Publications/tabId/40/Default.aspx>

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2 Working with Connecticut Medical Assistance Program

This section describes how to interact with Connecticut Medical Assistance Program's EDI Department.

Before Connecticut Medical Assistance Program can process transactions, the submitter must obtain a trading partner ID, create a Secure Web Portal user account and complete testing. Additional information is provided in the next section of this companion guide. Trading partners should exchange electronic health care transactions with Connecticut Medical Assistance Program via the Secure Web Portal or CT MMIS Safe Harbor connection.

After establishing a transmission method and completing required documentation, each trading partner must successfully complete testing. Additional information is provided in the next section of this companion guide. After successful completion of testing, production transactions may be exchanged.

2.1 Trading Partner Registration

To register as a Trading Partner with Connecticut Medical Assistance Program, visit the enrollment section of the public information section of the Connecticut Medical Assistance program website at <http://www.ctdssmap.com/> to complete the *Trading Partner Enrollment Profile Agreement*.

If there are questions regarding the Trading Partner Agreement, please contact our EDI Operations department at 1-800-842-8440 option 3 or email your inquiries to CTEDIsupport@dxc.com.

2.2 Certification and Testing Overview

All entities who wish to submit electronic transactions to Connecticut Medical Assistance Program in the HIPAA standard ASC X12 5010 format and receive any corresponding EDI responses must complete testing to ensure that their connections, systems, and software can and will produce data that is able to be processed by Connecticut Medical Assistance Program. This testing process certifies the trading partner can submit compliant files and receive and process the response files.

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3 Testing with the Payer

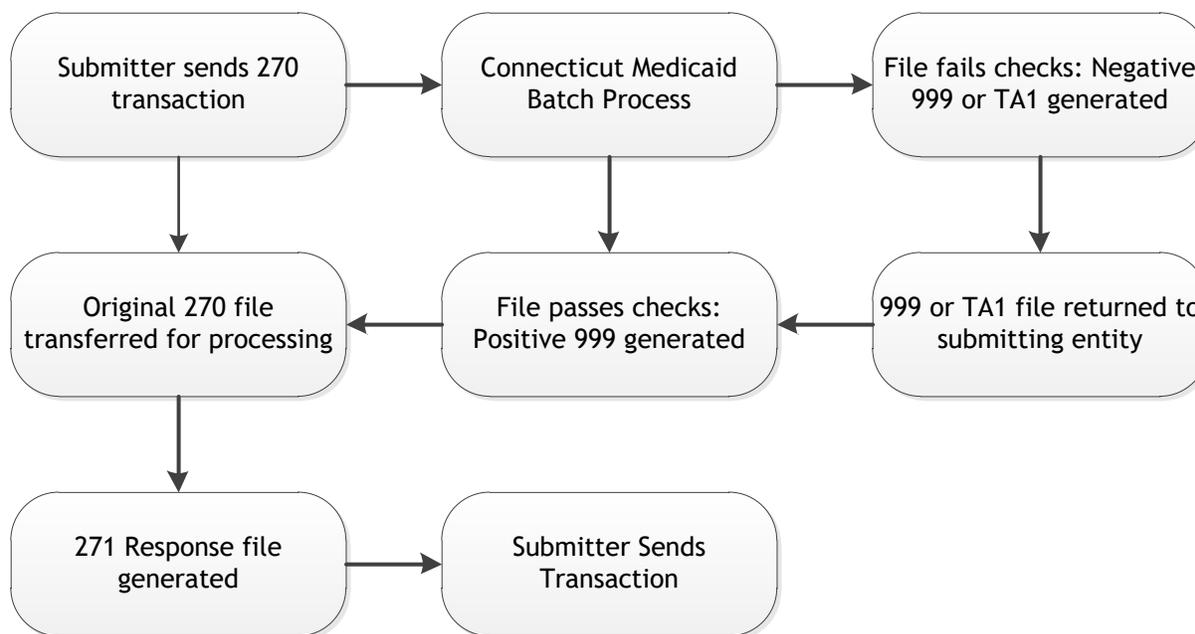
All submitters wishing to test their electronic transactions before submitting production files to Connecticut Medicaid are required to test and then fax a copy of the accepted 999, showing the test for the transaction was successful. Testing is accomplished by submitting the 270 with a “T” in ISA15. Test files are checked for HIPAA compliance. Trading partners may request assistance from the EDI department to help diagnose any issues that would cause submitted electronic files to reject. After Gainwell Technologies receives and processes the testing fax, the Trading Partner will receive a letter notifying them of their production status. Until this notice is received and the Trading Partner changes their Test /Production indicator from T to P, the transaction will not be processed by Gainwell Technologies. Required HIPAA EDI Testing procedures can be found at the following link:

<https://www.ctdssmap.com/CTPortal/Trading%20Partner/EDI/tabId/61/Default.aspx>

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4 Connectivity with the Payer/Communications

4.1 Process Flow



4.2 Transmission Administrative Procedures

Gainwell Technologies supports several types of data transport depending upon the Trading Partner's need. Trading partners can submit and receive data via the Secure Web Portal or CT MMIS Safe Harbor for batch transactions, and Value Added Networks (VANs) or CT MMIS Safe Harbor for interactive transactions. Trading Partners exchange batch and interactive transactions with the Connecticut Medical Assistance Program.

Batch X12 transactions are uploaded and downloaded via a Web-based application or the CT MMIS Safe Harbor connection. A Functional Acknowledgement is created for batch claim transactions once the syntactical analysis is complete. Generally, all batches are processed within 24 hours of receipt and Functional Acknowledgements are available for download during that time.

Interactive X12 transactions are processed interactively either by using the Safe Harbor connection or by using the services of a Value Added Network (VAN) which supplies software and the interface to the Connecticut Medical Assistance Program.

1. Secure Web Portal: Transaction files are uploaded/downloaded in the Trade Files menu on the Secure Web Portal.

2. VANs typically support interactive transactions through a dedicated connection. VANs sign a contract with the State and have unique, VAN- specific communication arrangements.
3. CT MMIS Safe Harbor: supports batch or interactive using MIME or SOAP.

Detailed information to assist with EDI related processes are available on the Provider Public website at <http://www.ctdssmap.com/>. Information available includes:

1. Required HIPAA EDI Testing procedures for all new trading partners
2. Web Upload/Download instructions for submitters uploading/downloading via the Secure Web Portal.
3. Web Upload/Download instructions for submitters uploading/downloading using a script to connect to Secure Web Portal using Vendor Interface Specifications.
https://www.ctdssmap.com/CTPortal/portals/0/StaticContent/Publications/vendor_interface_specs.pdf
4. Safe Harbor companion guide.
https://www.ctdssmap.com/CTPortal/portals/0/StaticContent/Publications/safeharbor_companion_guide.pdf

4.3 Re-Transmission Procedure

When the entire 270 file is rejected with either a TA1 or 999 responses, no 271 transaction will be generated. Upon receipt of the file rejection notice, the originating submitter should review and correct the 270 file and resubmit the entire 270 file.

When the system is unable to provide the eligibility of a requested client because of invalid or incomplete data on the incoming 270 transaction, a 271 transaction will be generated with an AAA segment in the relevant loop. Upon receipt of this 271 transaction, the originating submitter may review the accompanying code to rectify or correct the rejected request and resubmit the request on a new 270 transaction.

4.4 Communication Protocol Specifications

Connecticut Medical Assistance Program accepts 270 transactions via the following methods:

1. Secure Web Portal; batch mode
2. Secure Sockets Layer (SSL) for approved Value Added Networks; real-time.
3. Safe Harbor MIME or SOAP

4.5 Passwords

All submitters wishing to submit 270 transactions in batch to Connecticut Medical Assistance Program must have a presence in the secure Web Portal. Instructions on setting up web portal account and changing passwords are available in Chapter 10 of the Provider Manual.

https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=ch10_AVRS_web.pdf&URI=Manuals/ch10_AVRS_web.pdf

5 Contact Information

5.1 EDI Customer Service

For all EDI related inquiries, please contact Connecticut Medical Assistance Program EDI Operations Support:

Phone: 1-800-842-8440
1-866-604-3470
(alternate TTY/TDD line)

Email: CTEDISupport@dxc.com

5.2 Provider Assistance Center Number

For recipient eligibility information, claim status, billing and payment inquiries, and questions about the Connecticut Medical Assistance Program secure Web Portal, including Direct Data Entry (DDE) claims, please contact Provider Assistance Center. Customer service representatives are available from 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding holidays, by calling toll free at 1-800-842-8440. Providers are also offered a TDD/TTY number for assistance in obtaining necessary program information at 1-800-842-8440 or 1-866-604-3470 (alternate TTY/TDD line)

5.3 Relevant Websites

CT Medical Assistance Program (public site) – <http://www.ctdssmap.com/>

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

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6 Control Segments/Envelope Definitions for Eligibility Transactions

6.1 ISA – Interchange Control Header Segment

The Connecticut Medical Assistance Program accepts files with multiple ISA through the Secure Web Portal – Trade Files menu. When uploading files with multiple ISA/IEA to the Secure Web Portal, use the Web Transaction Type “HIPAA (x12 w/Multi-ISA)”.

Eligibility Request and Response					
Page	Loop ID	Reference	Name	Code/Value	Notes/Comments
C.3	N/A	ISA	Interchange Control Header Segment		
C.4	N/A	ISA01	Authorization Information Qualifier	00	CT Medicaid processes request with value of ‘00’ – No Authorization Information Present
C.4	N/A	ISA03	Security Information Qualifier	00	CT Medicaid processes request with value of ‘00’ – No Security Information Present
C.4	N/A	ISA05	Interchange ID Qualifier	ZZ	CT Medicaid processes request with value of ‘ZZ’ – Mutually Defined
C.4	N/A	ISA06	Interchange Sender ID		270 = Trading Partner ID as supplied by Connecticut Medical Assistance Program, left justified and space filled. 271 = ‘445498161’ left justified and space filled. Connecticut Medical Assistance Program Sender ID.
C.5	N/A	ISA07	Interchange ID Qualifier	ZZ	CT Medicaid processes request with value of ‘ZZ’ – Mutually Defined

Eligibility Request and Response					
Page	Loop ID	Reference	Name	Code/Value	Notes/Comments
C.5	N/A	ISA08	Interchange Receiver ID	445498161	270 = '445498161' left justified and space filled. Connecticut Medical Assistance Program Sender ID 271 = Trading Partner ID as supplied by Connecticut Medical Assistance Program, left justified and space filled.
C.6	N/A	ISA15	Usage Indicator	P	CT Medicaid will process a 'P' – as Production Data and "T" as Test data

6.2 GS – Functional Group Header

Eligibility Request and Response					
Page	Loop ID	Reference	Name	Code/Value	Notes/Comments
C.7	N/A	GS02	Application Sender's Code		270 = Trading Partner ID Supplied by Connecticut Medical Assistance Program, left justified, do not space fill. 271 = '445498161' – Connecticut Medical Assistance Program Sender ID
C.7	N/A	GS03	Application Receiver's Code		270 = '445498161' left justified do not space fill. Connecticut Medical Assistance Program Receiver ID 271 = Trading Partner Supplied by Connecticut Medical Assistance Program.

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7 Connecticut Medical Assistance Program Business Rules and Limitations – Eligibility Transactions

7.1 Business Rules

This section contains Payer-specific business rules and limitations for the 270 Health Care Eligibility Inquiry transactions.

Subscriber, Insured

The Subscriber refers to the patient in the Connecticut Medicaid Eligibility Verification System. The Connecticut Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/members are primary subscribers within each program.

Provider Identification

The Provider Identification refers to the National Provider Identifier (NPI) or AVRS ID (Providers without an NPI only).

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated the implementation of a National Provider Identifier (NPI). Most health care providers must register with the National Plan and Provider Enumeration System (NPPES) and receive a unique NPI. The intent of the HIPAA regulations was to require all health plans to convert their claims processing systems to use only the NPI for claims processing and reporting for providers required to obtain an NPI. Because of the complexities of this conversion by health care plans and providers, the use of the NPI has not yet been strictly enforced.

Beginning on **January 1, 2011**, the NPI is required on all electronic transactions from providers who qualify for an NPI. Connecticut Medical Assistance Program still accepts transactions containing the Provider's Automated Voice Response System (AVRS ID), but any qualifying claims that lack the NPI are denied.

For all atypical providers where an NPI is not assigned, the request should contain the Connecticut Medical Assistance Program AVRS Number in the 2100B loop, where NM108 = "SV" and NM109= 9 digit AVRS ID.

Dates:

2100C DTP segment can be included for the documented inquiries. If no DTP segment sent for "291" – Plan, processing date will be used as eligibility date.

For a single plan, CT will return only DTP qualifier "307" with RD8 at 2110C loop.

The 2110C DTP segment will only be returned if deductible applies to the plan.

The 2100C DTP may include From and To Dates of service in the future up to the end of the current month.

Logical File Structure

1. For Batch 270/271 transactions, there can be multiple interchange (ISA-IEA) per logical file, but must be uploaded indicating such. See reference to multiple ISA in Section 6.1. The interchange can contain multiple functional groups (GS-GE) however; the functional groups must be the same type.
2. For Interactive 270/271 transactions, there can only be one interchange (ISA-IEA), one functional group (GS-GE) and one transaction (ST-SE) per logical file. Within the transaction (ST-SE) there can only be one request. This has been defined as the EQ segment within Loop 2110C.
3. For Batch 270/271 transactions, if multiple information source loops (1000A) are received within the 270 transaction (ST-SE), then multiple 271 transactions (ST-SE) are generated. For example: 270 submitted with one ST-SE, within that ST-SE there are two information source loops; the 271 returned contains two ST-SEs.
4. For Batch 270/271 transactions, if multiple information receiver loops (1000B) are received within the 270 transaction (ST-SE), then multiple 271 transactions (ST-SE) are generated. For example: 270 submitted with one ST-SE, within that ST-SE there are two information receiver loops; the 271 returned contains two ST-SEs.
5. For Batch 270/271 transactions, to ensure a timely response, it is suggested that the submitter send more than one inquiry (EQ segment) within a transaction set (ST-SE), but no more than 5,000 inquiries (EQ segments) per transaction set (ST-SE). For example: A 270 batch submitted with 10,000 inquiries would have one ISA-IEA, 1 GS-GE, and 2 ST-SE (5,000 inquiries per ST-SE). Should you have a system limitation that requires you to send one transaction (EQ) per ST-SE, then we recommend you limit your file to reflect 5,000 ST-SE.
6. To ensure that eligibility information is only returned to active providers, the Connecticut Medical Assistance Program system attempts to perform a validation of the provider's NPI information as submitted on the 270 transaction to map it to a unique AVRS ID. On the 270 transaction, this information is limited to the NPI and accompanying taxonomy code. Sending the correct taxonomy for the NPI will help assure that the inbound transaction is credited to the correct provider profile and will prevent issues when an NPI is linked to both active and inactive profiles.

Valid Combinations of Subscriber Data for Eligibility Requests

There are six valid data combinations that the Connecticut Medical Assistance Program uses to identify a unique client.

1. Client ID & DOB
2. Client ID & SSN
3. Client ID & Card Issue Date
4. SSN & DOB
5. Client First & Last Name* & DOB
6. Client First & Last Name* & SSN

* Middle initial is not required for these data combinations. However, it may be beneficial to include it, as it may be needed to locate a unique client. The system will first try to locate a unique client with first name, last name, and DOB (or SSN). If multiple clients are found, the system will try a second time with first name, last name, middle initial, and DOB (or SSN).

For each 270 inquiry transmitted, the system looks for a valid combination of data in the order presented above. Once a valid combination is found, that combination is used to search for a unique client.

The appropriate error will be returned in the 2100C AAA segment if no valid combination of data is found, if any of the data is invalid, or if a single unique client could not be found.

Note: The data combinations above reflect the data that is used to identify a unique client. They do not represent data element requirements for the Health Care Eligibility Transaction.

Note: If a date of service is not received, the system uses the date of transmission as the default date.

Submitter

Submissions by non-approved trading partners are rejected.

Response/999 Functional Acknowledgement

A response transaction is returned to the trading partner that is present within the ISA06 data element.

An accepted 999 Implementation Acknowledgement, rejected 999 Implementation Acknowledgement, or rejected TA1 InterChange Acknowledgement will be generated in response to all submitted files.

You will receive this acknowledgment within 24 hours, unless there are unforeseen technical difficulties. If the transaction submitted was translated without errors for the 270 request, you will receive the appropriate response transaction generated from the request.

Document Level

Connecticut Medical Assistance Program processes 270 eligibility transaction files at the batch

level. Should any of the inquiries on the submitted batch fail to pass HIPAA compliance, the entire batch fails compliance and the erroneous data are reported on the 999.

Dependent Loop

The subscriber is always the same as the patient (dependent). Inquiries containing data in the Dependent Hierarchical Level (2000D loop) will not use this data to process the Eligibility Request.

Compliance Checking

Inbound 270 transactions are validated through Strategic National Implementation Process (SNIP) Level 4.

8 Acknowledgements

All 270 Eligibility transactions submitted to the Connecticut Medical Assistance program will generate at least one acknowledgment and/or response.

8.1 Report Inventory

999 Functional Acknowledgement

The 999 Acknowledgement is used to report the result of the analysis of the inbound transactions' compliance with the HIPAA standards set out in the 5010 X12 Transaction Report, assuming the file itself is sent to the Connecticut Medical Assistance Program system in a readable format.

The 999 will become available for retrieval within 24 hours of receipt of an uploaded batch file.

For real-time transactions, 999 Functional Acknowledgements will only be generated in cases where the originating transaction failed HIPAA compliance and the system was unable to produce a valid 271 transaction.

TA1 Acknowledgment

The TA1 Acknowledgement is generated when the submitted file contains errors in the Header-Trailer logic (ISA-IEA), causing the file itself to fail before it reaches the EDI system. When a TA1 Acknowledgement is generated, the system will not generate a 999 or a 271 response.

271 Health Care Eligibility Response Transaction

The 271 Eligibility Response files are generated when a submitted 270 file completely passes the HIPAA compliance checks performed by Connecticut Medical Assistance Program's EDI system. Compliance for Health Care Eligibility transactions are performed on a batch level. If any transaction within the batch fails compliance, the system considers the entire batch as a failed file and will not generate a 271 Response.

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9 Trading Partner Agreements

9.1 Trading Partners

A Trading Partner is defined as any entity (providers, billing services, software vendors, clearinghouses, etc.) that has an agreement with the payer to transmit electronic data files to, or receive electronic data files from, Connecticut Medical Assistance Program.

For Connecticut Medical Assistance program purposes, any provider that transmits their electronic files directly to the payer (i.e., via the Secure Web Portal) can be considered their own Trading Partner.

To register as a Trading Partner with Connecticut Medical Assistance program, an entity representative must complete the Trading Partner agreement available on Connecticut Medical Assistance Program's public website and submit it via the Web.

The Trading Partner agreement specifies which electronic transactions the submitter wishes to be able to submit and receive from Connecticut Medical Assistance program.

The agreement also allows Medicaid Providers to assign existing Trading Partners to their profile, giving these entities the right to submit electronic files to Connecticut Medical Assistance program on their behalf.

Connecticut Medical Assistance program Trading Partner Agreement link:

<https://www.ctdssmap.com/CTPortal/Trading%20Partner/Trading%20Partner%20Enrollment/Profile/tabId/60/Default.aspx>

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10 Eligibility Inquiry – Transaction Specific Information

This section specifies the fields for which Connecticut Medical Assistance program has specific requirements for processing.

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA08	Interchange Receiver ID		For CT Medicaid sent "445498161"
2100A	NM103	Name Last or Organization Name		Organization Name, CT Medicaid suggest using "DXC/CTMAP"
2100A	NM109	Identification Code		For CT Medicaid sent "75-2548221"
2100B	NM108	Identification Code Qualifier		CT Medicaid processes request with values of "XX" – NPI "SV" – Service Provider Number

CT Medicaid will process the following DTP segments. If no DTP segment sent for "291" – Plan, CT Medicaid will use processing date as eligibility date.

Loop ID	Reference	Name	Codes	Notes/Comments
2100C	DTP01	Date/Time Qualifier		CT Medicaid processes request for "291" – Plan
2100C	DTP03	Date		CT Medicaid processing request dates that do not exceed 365 days prior to current date and date spans within a single calendar month.

Generic and explicit requests are processed by CT Medicaid. "30" (Health Benefit Plan Coverage) submitted in EQ01 will generate a generic response. Explicit requests for Service Type Codes are processed. Any non-covered Service Type Codes will be listed in the Inactive EB segment. Note that a request for an unsupported Service Type Code will generate a generic response.

Loop ID	Reference	Name	Codes	Notes/Comments
2100C	EQ01	Service Type Code		Default for CT Medicaid should be "30" – Health Benefit Plan Coverage. Limit of 35 EQ01 values

11 Eligibility Response – Transaction Specific Information

This section specifies fields for which Connecticut Medical Assistance program has specific requirements for processing.

Loop ID	Reference	Name	Codes	Notes/Comments
2000A	AAA03	Reject Reason Code		CT Medicaid can return “42” – Unable to Respond at Current Time
2100B	AAA03	Reject Reason Code		CT Medicaid can return “50” – Provider Ineligible for Inquiries or “51” – Provider Not on File

Repeating Segment Begins: 1 st Occurrence: Echo Trace Number from 270 Request 2 nd Occurrence: CT Medicaid Interchange MMIS Assigned Trace Number

Loop ID	Reference	Name	Codes	Notes/Comments
2000C	TRN	Subscriber Trace Number		
2000C	TRN03	Originating Company Identifier		CT Medicaid will send “9445498161”

Loop ID	Reference	Name	Codes	Notes/Comments
2100C	DTP01	Date/Time Qualifier		CT Medicaid will send “307” – Eligibility, “346” – Plan Begin. For Multiple Plans, CT Medicaid will return only DTP qualifier “307” with RD8 at this loop.

Eligible Response – Repeating Eligibility Segments Begin
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Subscriber Eligibility: Active coverage – CT Medicaid will return an active coverage segment for each covered benefit plan. Deductible information will also be returned for each covered benefit plan.

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	DTP01	Date/Time Qualifier		CT Medicaid will return “307” – Eligibility, “346” – Plan Begin. For a single plan, CT Medicaid will return only DTP qualifier “307” with RD8 at this loop.
2110C	MSG01	Free-form Message Text	See Appendix 5 for Benefit messages.	CT Medicaid will return Additional information about the CT Medicaid Plans. If future DOS, up to end of current month, was submitted in inquiry, the following message will appear in the 271: “The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.”

Subscriber Eligibility: Base Deductible

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return “C” – Deductible
2110C	EB03	Service Type Code		CT Medicaid will return “30” – Health Benefit Plan Coverage
2110C	EB06	Time Period Qualifier		CT Medicaid will return “22” – Service Year
2110C	EB07	Monetary Amount		CT Medicaid will return Annual Base Deductible Amount – if the amount is 0.00, deductible does not apply to the plan
2110C	DTP	Subscriber Date		CT will only return this DTP segment if deductible applies to the plan.
2110C	DTP01	Date/Time Qualifier		CT Medicaid will return “291” – Plan

Subscriber Eligibility: Remaining Deductible
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Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		CT Medicaid will return this EB segment if deductible applies to the plan and if the request date encompasses the current date.
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return "C" – Deductible
2110C	EB03	Service Type Code		CT Medicaid will return "30" – Health Benefit Plan Coverage
2110C	EB06	Time Period Qualifier		"CT Medicaid will return 29" – Remaining

Subscriber Eligibility: Base Stop Loss – Includes Deductible and Coinsurance
--

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		CT Medicaid will return this EB segment if stop loss applies to the plan and if the request date encompasses the current date.
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return "G" – Stop Loss
2110C	EB03	Service Type Code		CT Medicaid will return "30" – Health Benefit Plan Coverage
2110C	EB06	Time Period Qualifier		CT Medicaid will return "22" – Service Year
2110C	MSG01	Free-form Message Text		CT Medicaid will return " INCLUDES DEDUCTIBLE AND COINSURANCE"

Subscriber Eligibility: Remaining Stop Loss – Includes Deductible and Coinsurance

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		CT Medicaid will return this EB segment will only be returned if Stop Loss applies to the plan and if the request date encompasses the current date.
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return “G” – Stop Loss
2110C	EB03	Service Type Code		CT Medicaid will return “30” – Health Benefit Plan Coverage
2110C	EB06	Time Period Qualifier		CT Medicaid will return “29” – Remaining
2110C	MSG01	Free-form Message Text		CT Medicaid will return “INCLUDES DEDUCTIBLE AND COINSURANCE”

Service Type Code and Copay and Coinsurance for All Covered Benefit Plans

Subscriber Eligibility: Covered Service Type Codes

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return “1” – Active Coverage
2110C	EB03	Service Type Code		This may repeat up to 35 times for CT Medicaid

Subscriber Eligibility: Inactive Service Type Codes

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return “6” – Inactive

Subscriber Eligibility: Copay – a copay segment is returned by CT Medicaid for each distinct copay amount.

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return “B” – Copay
2110C	EB03	Service Type Code		This may repeat up to 35 times for CT Medicaid.
2110C	EB07	Monetary Amount		CT Medicaid will return Copay Amount

Subscriber Eligibility: Coinsurance – a coinsurance segment is returned by CT Medicaid for each distinct coinsurance percentage.

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return “A” – Coinsurance
2110C	EB03	Service Type Code		This may repeat up to 35 times for CT Medicaid
2110C	EB08	Percent		CT Medicaid will return Coinsurance Percentage

Other Insurance/Medicare Note: Data from CT Medicaid in the 2120C loop reflects basic information about other payer or plans. The receiver should initiate a separate request to the other payer or plan to determine level of coverage.

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return “R” – Other Or Additional Payer
2120C	NM101	Entity Identifier Code		CT Medicaid will return “PR” – Payer
2120C	NM108	Identification Code Qualifier		CT Medicaid will return “PI” – Payer Identification
2120C	NM109	Identification Code		CT Medicaid will return their 3 digit Insurance Carrier Code. See link to list below

<https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=Carrier%20Codes%20alpha.pdf&URI=Manuals/Carrier%20Codes%20alpha.pdf>

Pharmacy/Lock In Information

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return "N" – Services Restricted to Following Provider
2120C	NM101	Entity Identifier Code		CT Medicaid will return "1P" – Provider
2120C	NM103	Name Last or Organization Name		CT Medicaid will return Inmate Lock in / Pharmacy Last Name
2120C	NM108	Identification Code Qualifier		CT Medicaid will return "XX" – National Provider Identifier
2120C	PER01	Contact Function Code		CT Medicaid will return "IC"
2120C	PER03	Communication Number Qualifier		CT Medicaid will return "TE"

Hospice/Nursing Home Information

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return "X" – Health Care Facility
2120C	NM101	Entity Identifier Code		CT Medicaid will return "FA" – Facility
2120C	NM108	Identification Code Qualifier		CT Medicaid will return "XX" – National Provider Identifier
2120C	PER01	Contact Function Code		CT Medicaid will return "IC"
2120C	PER03	Communication Number Qualifier		CT Medicaid will return "TE"

Subscriber Eligibility: Dental Annual Benefit Maximum

Two EB segments will be returned. One will indicate the annual maximum amount and the other will indicate the remaining amount.

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return "F" – Limitations
2110C	EB03	Service Type Code		CT Medicaid will return "35" – Dental Care
2110C	EB06	Time Period Qualifier		CT Medicaid will return "23" –Calendar Year
2110c	EB07	Monetary Amount		CT Medicaid will return the dental annual maximum amount
2110C	DTP	Subscriber Date		CT will return this DTP segment for applicable dates the limitation is in effect.
2110C	DTP01	Date/Time Qualifier		CT Medicaid will return "291" – Plan
2110C	MSG01	Free-form Message Text		CT Medicaid will return "Claims not yet received or not yet processed may reduce available benefits. Eligibility verification and confirmation of coverage or remaining benefits is not a guarantee of payment"

Subscriber Eligibility: Remaining Dental Annual Benefit

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return "F" – Limitations
2110C	EB03	Service Type Code		CT Medicaid will return "35" –
2110C	EB06	Time Period Qualifier		CT Medicaid will return "29" – Remaining
2110c	EB07	Monetary Amount		CT Medicaid will return the dental annual maximum remaining amount
2110C	DTP	Subscriber Date		CT will return this DTP segment for applicable dates the limitation is in effect.
2110C	DTP01	Date/Time Qualifier		CT Medicaid will return "291" – Plan

Ineligible Response

Subscriber Eligibility: Client is not eligible.

Loop ID	Reference	Name	Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information Code		CT Medicaid will return "6" – Inactive
2110C	EB03	Service Type Code		CT Medicaid will return "30" – Health Benefit Plan Coverage
2110C	DTP01	Date/Time Qualifier		CT Medicaid will return "307" – Eligibility

Appendix 1. Implementation Checklist

This appendix contains all necessary steps for going live with Connecticut Medical Assistance Program.

1. Email the EDI staff at CTEDIsupport@dxc.com with any questions about testing.
2. Check the website for the latest updates regarding our system implementation.
3. Confirm you have a Trading Partner ID, Secure Web Portal User Name and Provider ID.
4. Make the appropriate changes to your systems/business processes to support the updated companion guides:
 - a. If you use third party software, work with your software vendor to have the appropriate software installed.
 - b. If testing system-to-system interface, the Trading Partner or provider must work with your software vendor to have the appropriate software installed at their site(s) prior to performing testing with Connecticut Medical Assistance Program.
5. Identify the functions you will be testing:
 - a. Health Care Eligibility/Benefit Inquiry and Information Response (270/271);
6. Confirm that you have reported all the NPIs you will use for testing by validating them with Connecticut Medical Assistance Program. If you have multiple CT AVRS provider IDs associated to one NPI and/or taxonomy code, ensure your request successfully reports data for your correct Provider ID.

Note: If the entity testing is a billing intermediary or software vendor, they should use the provider's identifier on the test transaction.
7. When submitting test files, make sure the file represents requests you will be submitting to Connecticut Medical Assistance Program once you are in production.
8. Schedule a tentative week for the initial test.
9. Confirm the email/phone number of the testing contact and confirm that the person you are speaking with is the primary contact for testing purposes.

Appendix 2. Business Scenarios

This appendix contains typical business scenarios for batch or interactive eligibility inquiries. The actual data streams linked to these scenarios are included in the Transmission Examples section.

An eligibility request for CT Medicaid should be submitted with one of the following criteria:

1. Client ID and Date of Birth;
2. Client ID and Social Security Number;
3. Client ID and Card Issue Date;
4. Social Security Number and Date of Birth;
5. Last name, First Name, and Date of Birth;
6. Last Name, First Name, and Social Security Number;

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Appendix 3. Transmission Examples

3.1 Inquiry by Client ID and Date of Birth

ST*270*604493536*005010X279A1~
BHT*0022*13*604491111*20120207*0659~
HL*1**20*1~
NM1*PR*2*DXC/CTMAP*****PI*75-2548221~
HL*2*1*21*1~
NM1*1P*2*NAME*****XX*999999999~
HL*3*2*22*0~
TRN*1*604493536*888888888~
NM1*IL*1*****MI*012345678~
DMG*D8*19821221*M~
DTP*291*RD8*20130107-20130107~
EQ*30~
SE*13*604493536~

3.2 Inquiry by Client ID and Social Security Number

ST*270*604493536*005010X279A1~
BHT*0022*13*604491111*20120207*0659~
HL*1**20*1~
NM1*PR*2*DXC/CTMAP*****PI*75-2548221~
HL*2*1*21*1~
NM1*1P*2*NAME*****XX*999999999~
HL*3*2*22*0~
TRN*1*604493536*888888888~
NM1*IL*1*****MI*012345678~
REF*SY*111111111~
DTP*291*RD8*20130107-20130107~
EQ*30~
SE*13*604493536~

3.3 Inquiry by Client ID and Card Issue Date

ST*270*604493536*005010X279A1~
BHT*0022*13*604491111*20120207*0659~
HL*1**20*1~
NM1*PR*2*DXC/CTMAP*****PI*75-2548221~
HL*2*1*21*1~
NM1*1P*2*NAME*****XX*999999999~
HL*3*2*22*0~
TRN*1*604493536*888888888~
NM1*IL*1*****MI*012345678~
DTP*102*D8*20180101~
DTP*291*RD8*20130101-20130101~
EQ*30~
SE*13*604493536~

3.4 Inquiry by Date of Birth and Social Security Number

ST*270*604493536*005010X279A1~
BHT*0022*13*604491111*20120207*0659~
HL*1**20*1~
NM1*PR*2*DXC/CTMAP*****PI*75-2548221~
HL*2*1*21*1~
NM1*1P*2*NAME*****XX*999999999~
HL*3*2*22*0~
TRN*1*604493536*888888888~
NM1*IL*1*LASTNAME*FIRSTNAME~
DMG*D8*19821221*M~
REF*SY*111111111
DTP*291*RD8*20130101-20130101~
EQ*30~
SE*14*604493536~

3.5 Inquiry by Last Name, First Name, and Date of Birth

ST*270*604493536*005010X279A1~
BHT*0022*13*604491111*20120207*0659~
HL*1**20*1~
NM1*PR*2*DXC/CTMAP*****PI*75-2548221~
HL*2*1*21*1~
NM1*1P*2*NAME*****XX*999999999~
HL*3*2*22*0~
TRN*1*604493536*888888888~
NM1*IL*1*LAST NAME*FIRST NAME~
DMG*D8*19821221*M~
DTP*291*RD8*20130101-20130101~
EQ*30~
SE*13*604493536~

3.6 Inquiry by Last Name, First Name, and Social Security Number

ST*270*604493536*005010X279A1~
BHT*0022*13*604491111*20120207*0659~
HL*1**20*1~
NM1*PR*2*DXC/CTMAP*****PI*75-2548221~
HL*2*1*21*1~
NM1*1P*2*NAME*****XX*999999999~
HL*3*2*22*0~
TRN*1*604493536*888888888~
NM1*IL*1*LAST NAME*FIRST NAME~
REF*SY*111111111
DTP*291*RD8*20130101-20130101
EQ*30~
SE*13*604493536~

Appendix 4. Frequently Asked Questions

The following link will bring you to a list of the most frequently asked questions regarding HIPAA.

<https://www.ctdssmap.com/CTPortal/Information/HIPAA/tabId/42/Default.aspx>.

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Appendix 5. Benefit Messages

Benefit Plan	Message
HSKYA	Husky A. For Behavioral Health Services, call BHP at 877-552-8247.
HSKYB	HUSKY B. For Behavioral Health Services, call BHP at 877-552-8247. Please refer to the companion guide for all Husky B copays.
BHP D	Limited Behavioral Health Services only. Contact CT BHP at 877-552-8247.
CADAP	Drug coverage only, under the CADAP Program. **Effective for dates of service November 1, 2018 and forward the CADAP plan has transitioned to Magellan Rx Management.
CBCMS	CT Home Care Community Based Case Managed State Funded
CHOAK	Charter Oak. For Behavioral Health Services, call BHP at 877-552-8247. Please refer to the companion guide for all Charter Oak copays. Effective end date 12/31/2013
CP	Drug coverage only, under the ConnPACE Program. Effective end date 12/31/2013
FAMPL	Family Planning Services Only
HSKYC	Husky C. For Behavioral Health Services, call BHP at 877-552-8247.
HSKYD	Husky D. For Behavioral Health Services, call BHP at 877-552-8247.
QMB	Medicare Covered Services
TB	Tuberculosis Covered Services Only

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Appendix 6. Change Summary

Document Version #	Modified Date	Modified By	Section, Page(s) and Text Revised
Version 1.0	3/15/2013	Donna Canady	Creation of document -
Version 1.1	8/26/2013	Donna Canady	Updated format before requesting copyright
Version 1.2	10/24/2013	Donna Canady	Added effective end date to references to ConnPace and Charter Oak
Version 1.3	12/23/2014	Donna Canady	Removed segments that are same as IG/ TR3 and changed wording throughout to confirm to ACS X12 copyright permission rules.
Version 1.4	12/3/2015	Kelly LeBlanc	HP to Hewlett Packard Enterprise updates
Version 1.5	4/10/2017	Kelly LeBlanc	Hewlett Packard Enterprise to Gainwell Technologies updates
Version 1.6	1/1/2018	Donna Canady	Added to section 11 page 36 to reflect dental annual benefit maximum
Version 1.7	7/24/2018	Donna Canady	Added new search criteria 5 and 6 on page 23
Version 1.8	11/1/2018	Kelly LeBlanc	CADAP transition to DPH/Magellan

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