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# 270/271 Batch and Interactive Health Care Eligibility and Response Transaction Companion Guide

## 005010 X279A1

**Version 1.0**

**February 2013**

**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.

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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 HIPAA 5010 270/271 (referred to as Eligibility and Benefit 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

The Charter Oak Health Plan publishes information about Husky co- insurance, deductible and copay. Information can be found at the following link:
http://www.huskyhealthct.org/providers/benefits_authorizations.html

## 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
.

# 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 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 Portal.

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 obtain and complete the *Trading Partner Enrollment Profile Agreement*.

If there are questions regarding the EDI agreement, please contact our EDI Operations department at 1-800-842-8440 option 3 or email your inquiries to CTEDIsupport@hp.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 HIPPA compliance. Trading partners may request assistance from the EDI department to help diagnose any issues that would cause submitted electronic files to reject. After HP 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 HP. 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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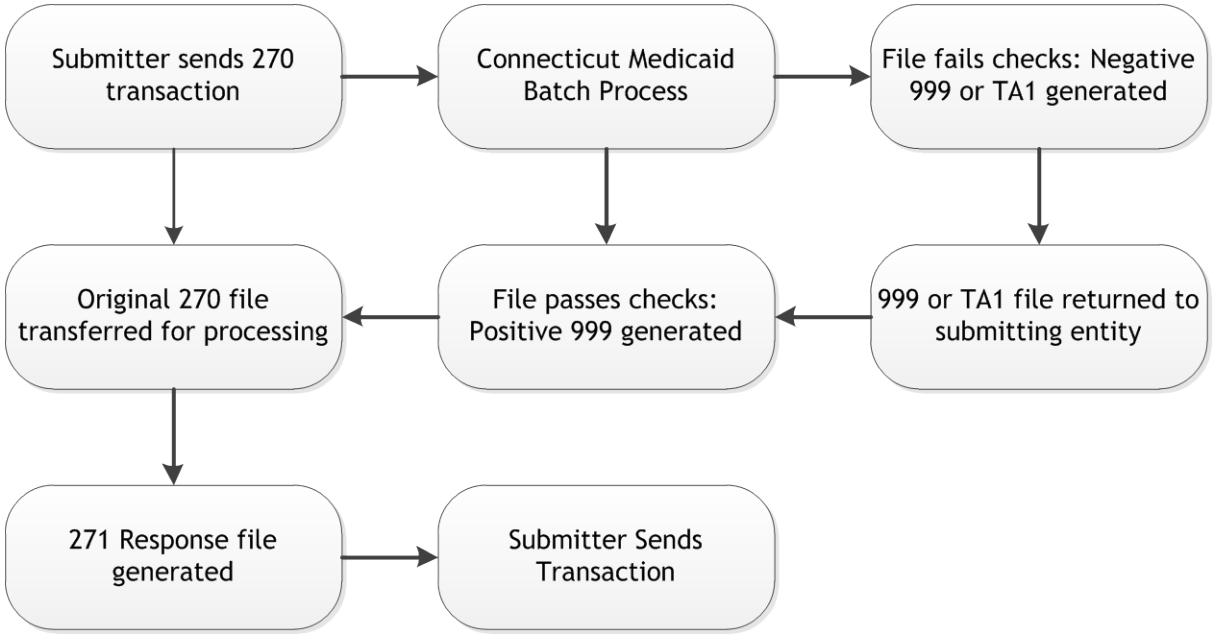
# 4 Connectivity with the Payer/Communications

## 4.1 Process Flow




## 4.2 Transmission Administrative Procedures

HP supports several types of data transport depending upon the Trading Partner's need. Providers and their representatives can submit and receive data via the Web Portal for batch transactions and Value Added Networks (VANs) 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. 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 interactive through a Value Added Network rather than directly submitting to the Connecticut Medical Assistance Program.

1. 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.

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 Web Portal using Vendor Interface Specifications . https://www.ctdssmap.com/CTPortal/portals/0/StaticContent/Publications/vendor_interface_specs.pdf

## 4.3 Re-Transmission Procedure

When the entire 270 file is rejected with either a TA1 or 999 response, 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.

## 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 our Web/ AVRS manual. https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=ch10_iC_web_avrs.pdf&URI=Manuals/ch10_iC_web_avrs.pdf page 38-41.

# 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@hp.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 270/271 Transactions

## 6.1 ISA - Interchange Control Header Segment

This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

The Connecticut Medical Assistance Program accepts files with multiple ISA. When uploading files with multiple ISA/IEA, use the Web Transaction Type “HIPAA (x12 w/Multi-ISA)”.

| 270/271 Health Care 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 | '00' - No Authorization Information Present |
| C.4 | N/A | ISA02 | Authorization Information | | [space fill] |
| C.4 | N/A | ISA03 | Security Information Qualifier | 00 | '00' - No Security Information Present |
| C.4 | N/A | ISA04 | Security Information | | [space fill] |
| C.4 | N/A | ISA05 | Interchange ID Qualifier | ZZ | '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.<br>271 = '445498161' left justified and space filled. Connecticut Medical Assistance Program Sender ID. |
| C.5 | N/A | ISA07 | Interchange ID Qualifier | ZZ | 'ZZ' - Mutually Defined |

| 270/271 Health Care 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.5 | N/A | ISA09 | Interchange Date | | The date format is YYMMDD. |
| C.5 | N/A | ISA10 | Interchange Time | | The time format is HHMM. |
| C.5 | N/A | ISA11 | Repetition Separator | ^ | '^' |
| C.5 | N/A | ISA12 | Interchange Control Version Number | 00501 | '00501' - Control Version Number |
| C.5 | N/A | ISA13 | Interchange Control Number | | Interchange Unique Control Number - Must be identical to IEA02 |
| C.6 | N/A | ISA14 | Acknowledgement Requested | 1 | '1' - Acknowledgement Requested |
| C.6 | N/A | ISA15 | Usage Indicator | P | 'P' - Production Data, “T” Testing only |
| C.6 | N/A | ISA16 | Component Element Separator | : | ':' - Component Element Separator |

## 6.2 IEA – Interchange Control Trailer

This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

| 270/271 Health Care Eligibility Request and Response | | | | | |
|---|---|---|---|---|---|
| **Page** | **Loop ID** | **Reference** | **Name** | **Code/Value** | **Notes/Comments** |
| C.10 | N/A | IEA | Interchange Control Trailer | | |
| C.10 | N/A | IEA01 | Number of Included Functional Groups | | Number of included Functional Groups |
| C.10 | N/A | IEA02 | Interchange Control Number | | Must be identical to the value in ISA13 |

## 6.3 GS – Functional Group Header

This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

| 270/271 Health Care Eligibility Request and Response | | | | | |
|---|---|---|---|---|---|
| **Page** | **Loop ID** | **Reference** | **Name** | **Code/Value** | **Notes/Comments** |
| C.7 | N/A | GS | Functional Group Header | | |
| C.7 | N/A | GS01 | Functional ID Code | HS, HB | 270 = 'HS' - Eligibility, Coverage or Benefit Inquiry<br>271 = 'HB' - Eligibility Coverage or Benefit Information |
| 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.<br>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<br>271 = Trading Partner Supplied by Connecticut Medical Assistance Program. |
| C.7 | N/A | GS04 | Date | | The date format is CCYYMMDD. |
| C.8 | N/A | GS05 | Time | | The time format is HHMM. |
| C.8 | N/A | GS06 | Group Control Number | | Group Control Number - Must be identical to GE02. |
| C.8 | N/A | GS07 | Responsible Agency Code | X | 'X' - Responsible Agency Code |
| C.8 | N/A | GS08 | Version/ Release/ Industry Identifier Code | 005010X279A1 | Version/ Release/ Industry Identifier Code |

## 6.4 GE – Functional Group Trailer

This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

| 270/271 Health Care Eligibility Request and Response | | | | | |
|---|---|---|---|---|---|
| **Page** | **Loop ID** | **Reference** | **Name** | **Code/Value** | **Notes/Comments** |
| C.9 | N/A | GE | Functional Group Trailer | | |
| C.9 | N/A | GE01 | Number of Transaction Sets Included | | Number of included Transaction Sets |
| C.9 | N/A | GE02 | Group Control Number | | Must be identical to the value in GS06. |

## 6.5 ST – Transaction Set Header

This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

| 270/271 Health Care Eligibility Request and Response | | | | | |
|---|---|---|---|---|---|
| **Page** | **Loop ID** | **Reference** | **Name** | **Code/Value** | **Notes/Comments** |
| 59 | N/A | ST | Transaction Set Header | | |
| 59 | N/A | ST01 | Transaction Set Identifier Code | 270, 271 | 270 = Eligibility, Coverage or Benefit Inquiry<br>271 = Eligibility, Coverage or Benefit Information |
| 59 | N/A | ST02 | Transaction Set Control Number | | Transaction Control Number<br><br>Increment by 1 when multiple transaction sets are submitted.<br><br>Must be identical to SE02. |
| 60 | N/A | ST03 | Implementation Convention Reference | | Must be identical to the value in GS08. |

## 6.6 SE – Transaction Set Trailer

This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments [including the beginning (ST) and ending (SE) segments]. This segment may be thought of traditionally as the claim trailer record.

| 270/271 Health Care Eligibility Request and Response | | | | | |
|---|---|---|---|---|---|
| **Page** | **Loop ID** | **Reference** | **Name** | **Code/Value** | **Notes/Comments** |
| 199 | N/A | SE | Transaction Set Trailer | | |
| 199 | N/A | SE01 | Number of Included Segments | | Total number of segments included in Transaction Set including ST and SE |
| 199 | N/A | SE02 | Transaction Set Control Number | | Must be identical to the value in ST02 |

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# 7 Connecticut Medical Assistance Program Business Rules and Limitations - 270 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 must 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” – Eligibility, 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 2100C 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 only be one interchange (ISA-IEA) per logical file. 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. 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 three valid data combinations that can be used to determine a recipient's eligibility in the Connecticut Medical Assistance Program:

1. Client ID & SSN
2. Client ID & DOB
3. Client First and Last Name, SSN & DOB

For each 270 inquiry transmitted, the system looks for each of these data combinations in the order presented above. The system checks each combination of data until it is able to find a

Medicaid recipient that matches the data presented or until it has exhausted all three data combinations.

In cases where no valid match can be found, the system returns an AAA*N*75 in the 271, noting that the recipient in question could not be found.

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). Claims containing data in the Dependent Hierarchical Level (2000D loop) will not process correctly.

### Compliance Checking

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

## 7.2 Valid Delimiters

The delimiters documented below are used for Connecticut Medical Assistance Program, unless otherwise requested by a trading partner.

| Definition | ASCII | Decimal | Hexadecimal |
|---|---|---|---|
| Segment Separator | ~ | 126 | 7E |

| | | | |
|---|---|---|---|
| Element Separator | * | 42 | 2A |
| Compound Element Separator | : | 58 | 3A |
| Repetition Separator | ^ | 94 | 5E |

# 8 Acknowledgements

All 270 Eligiblity  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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# 10 270 Health Care Eligibility Inquiry - Transaction Specific Information

This section specifies X12N 270 fields for which Connecticut Medical Assistance program has specific requirements.

**005010X279 270 Transaction Set**

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | ISA | Interchange Control Header | | |
| | ISA08 | Interchange Receiver ID | | Always “445498161” |
| | BHT | Beginning of Hierarchical Transaction | | |
| | BHT02 | Transaction Set Purpose Code | | “13” – Request |
| 2100A | NM1 | Information Source Name | | |
| 2100A | NM101 | Entity Identifier Code | | “PR” – Payer |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2100A | NM102 | Entity Type Qualifier | | "2" – Non-Person Entity |
| 2100A | NM103 | Name Last or Organization Name | | Organization Name, Suggest using "HP/CTMAP" |
| 2100A | NM108 | Identification Code Qualifier | | "PI" – Payer Identification |
| 2100A | NM109 | Identification Code | | "75-2548221" |
| 2100B | NM1 | Information Receiver Name | | |
| 2100B | NM101 | Entity Identifier Code | | "1P" – Provider |
| 2100B | NM102 | Entity Type Qualifier | | "2" – Non-Person Entity |
| 2100B | NM108 | Identification Code Qualifier | | "XX" – NPI<br>"SV" - Service Provider Number |

Inquiry by Client ID & SSN

Connecticut Medical Assistance Program and ConnPACE. Note: Do not send 2100D or 2110D loop for CT. Patient is subscriber.

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2100C | NM1 | Subscriber Name | | |
| 2100C | NM101 | Entity Identifier Code | | "IL" – Insured or Subscriber |
| 2100C | NM102 | Entity Type Qualifier | | "1" – Person |
| 2100C | NM108 | Identification Code Qualifier | | "MI" – Client ID Number |
| 2100C | NM109 | Identification Code | | Client Identification Number |
| 2100C | REF | Subscriber Additional Identification | | |
| 2100C | REF01 | Reference Identification Qualifier | | "SY" – Social Security Number |
| 2100C | REF02 | Reference Identification | | Social Security Number |

Inquiry by Client ID & DOB

Connecticut Medical Assistance Program and ConnPACE. Note: Do not send 2100D or 2110D loop for CT. Patient is subscriber.

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2100C | NM1 | Subscriber Name | | |
| 2100C | NM101 | Entity Identifier Code | | "IL" – Insured or Subscriber |
| 2100C | NM102 | Entity Type Qualifier | | "1" – Person |
| 2100C | NM108 | Identification Code Qualifier | | "MI" – Client ID Number |
| 2100C | NM109 | Identification Code | | Client Identification Number |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2100C | DMG | Subscriber Demographic Information | | |
| 2100C | DMG01 | Date Time Period Format Qualifier | | "D8" – Date Expressed as CCYYMMDD |
| 2100C | DMG02 | Date Time Period | | Client Date of Birth |

Inquiry by Client Name, SSN & DOB

Connecticut Medical Assistance Program and ConnPACE. Note: Do not send 2100D or 2110D loop for CT. Patient is subscriber.

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2100C | NM1 | Subscriber Name | | |
| 2100C | NM101 | Entity Identifier Code | | "IL" – Insured or Subscriber |
| 2100C | NM102 | Entity Type Qualifier | | "1" – Person |
| 2100C | NM103 | **Name Last or Organization Name** | | Client last name |
| 2100C | NM104 | **Name First** | | Client first name |
| 2100C | REF | Subscriber Additional Identification | | |
| 2100C | REF01 | Reference Identification Qualifier | | "SY" – Social Security Number |
| 2100C | REF02 | Reference Identification | | Client Social Security Number |
| 2100C | DMG | Subscriber Demographic Information | | |
| 2100C | DMG01 | Date Time Period Format Qualifier | | "D8" – Date Expressed as CCYYMMDD |
| 2100C | DMG02 | Date Time Period | | Client Date of Birth |

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

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2100C | DTP | Subscriber Date | | |
| 2100C | DTP01 | Date/Time Qualifier | | "291" – Eligibility |
| 2100C | DTP03 | Date | | Request Dates may not exceed 365 days prior to current date. Request Date spans must be within a single calendar month. |

Generic and explicit requests are now supported. "30" (Health Benefit Plan Coverage) submitted in EQ01 will generate a generic response. Explicit requests for Service Type Codes listed in Appendix 6 will be supported. Combinations of generic and explicit requests will be

supported. 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 | EQ | Subscriber Eligibility or Benefit Inquiry | | |
| 2100C | EQ01 | Service Type Code | See list of supported Service Type Codes in Appendix 5 | Default should be "30" – Health Benefit Plan Coverage. Limit of 35 EQ01 values |

# 11 271 Health Care Eligibility Response - Transaction Specific Information

This section specifies X12N 271 fields for which Connecticut Medical Assistance program has specific requirements.

**005010X279 271 Transaction Set**

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2000A | AAA | Request Validation | | |
| 2000A | AAA01 | Yes/No Condition or Response Code | | "N" – No |
| 2000A | AAA03 | Reject Reason Code | | "42" – Unable to Respond at Current Time |
| 2100B | AAA | Information Receiver Request Validation | | |
| 2100B | AAA01 | Yes/No Condition or Response Code | | "N" – No |
| 2100B | AAA03 | Reject Reason Code | | "50" – Provider Ineligible for Inquiries<br>"51" – Provider Not on File |

Repeating Segment Begins:

1st Occurrence: Echo Trace Number from 270 Request (The segment is optional in the 270 Request.)

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2000C | TRN | Subscriber Trace Number | | |
| 2000C | TRN01 | Trace Type Code | | "2" – Referenced Transaction Trace Numbers |
| 2000C | TRN02 | Reference Identification | | This will be equal to the value in the 2000C – TRN02 data element that was received on the 270 request. |
| 2000C | TRN03 | Originating Company Identifier | | This will be equal to the value in the 2000C – TRN03 data element that was received on the 270 request. |

2nd Occurrence: Interchange MMIS Assigned Trace Number

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2000C | TRN | Subscriber Trace Number | | |
| 2000C | TRN01 | Trace Type Code | | "1" – Current Transaction Trace Numbers |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2000C | TRN02 | Reference Identification | | Sender Assigned Trace Number |
| 2000C | TRN03 | Originating Company Identifier | | Always “9445498161” |

Repeating Segment Begins:

1st Occurrence: Patient Account Number from 270 Request (The segment is optional in the 270 Request.)

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2100C | REF | Subscriber Additional Identification | | |
| 2100C | REF01 | Reference Identification Qualifier | | “EJ” – Patient Account Number |

2nd Occurrence: Social Security Number from 270 Request (The segment is optional in the 270 Request.)

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2100C | REF | Subscriber Additional Identification | | |
| 2100C | REF01 | Reference Identification Qualifier | | “SY” – Social Security Number |
| 2100C | AAA | Subscriber Request Validation | | |
| 2100C | AAA01 | Yes/No Condition or Response Code | | “N” – No |
| 2100C | AAA03 | Reject Reason Code | | Refer to Implementation Guide for Reject Reason Code and Definition. |
| 2100C | DMG | Subscriber Demographic Information | | |
| 2100C | DMG02 | Date Time Period | | Client Birth Date. Client Birth Date is returned in the 271 response when client match is found. |
| 2100C | DTP | Subscriber Date | | |
| 2100C | DTP01 | Date/Time Qualifier | | “307” – Eligibility, “346” – Plan Begin. For Multiple Plans, CT will return only DTP qualifier “307” with RD8 at this loop. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2100C | DTP02 | Date Time Period Format Qualifier | | "D8" – Date Expressed as CCYYMMDD if Qualifier 346<br>or<br>"RD8" – Date Expressed as CCYYMMDD-CCYYMMDD if qualifier 307 |

Eligible Response - Repeating Eligibility Segments Begin

Subscriber Eligibility: Active coverage – An active coverage segment will be created for each covered benefit plan. Deductible information will also be returned for each covered benefit plan.

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | "1" – Active Coverage |
| 2110C | EB03 | Service Type Code | | "30" – Health Benefit Plan Coverage |
| 2110C | EB04 | Insurance Type Code | | See list of valid Insurance Type Codes page 298-299 271 Implementation guide |
| 2110C | EB05 | Plan Coverage Description | | Description of benefit plan |
| 2110C | DTP | Subscriber Date | | |
| 2110C | DTP01 | Date/Time Qualifier | | "307" – Eligibility, "346" – Plan Begin. For a single plan, CT will return only DTP qualifier "307" with RD8 at this loop. |
| 2110C | DTP02 | Date Time Period Format Qualifier | | "D8" – Date Expressed as CCYYMMDD if Qualifier 346<br>or<br>"RD8" – Date Expressed as CCYYMMDD-CCYYMMDD if qualifier 307 |
| 2110C | MSG | Message Text | | |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | MSG01 | Free-form Message Text | See Appendix 6 for Benefit messages. | Additional information about the CT 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 | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | “C” – Deductible |
| 2110C | EB03 | Service Type Code | | “30” – Health Benefit Plan Coverage |
| 2110C | EB05 | Plan Coverage Description | | Description of benefit plan |
| 2110C | EB06 | Time Period Qualifier | | "22" – Service Year |
| 2110C | EB07 | Monetary Amount | | Annual Base Deductible Amount – if the amount is 0.00, deductible does not apply to the plan |
| 2110C | DTP | Subscriber Date | | The DTP segment will only be returned if deductible applies to the plan. |
| 2110C | DTP01 | Date/Time Qualifier | | "291" - Plan |
| 2110C | DTP02 | Date Time Period Format Qualifier | | “RD8” – Date Expressed as CCYYMMDD-CCYYMMDD |

Subscriber Eligibility: Remaining Deductible

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | EB | Subscriber Eligibility or Benefit Information | | This EB segment will only be returned if deductible applies to the plan and if the request date encompasses the current date. |
| 2110C | EB01 | Eligibility or Benefit Information Code | | “C” – Deductible |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | EB03 | Service Type Code | | “30” – Health Benefit Plan Coverage |
| 2110C | EB05 | Plan Coverage Description | | Description of benefit plan |
| 2110C | EB06 | Time Period Qualifier | | "29" – Remaining |
| 2110C | EB07 | Monetary Amount | | Remaining Deductible Amount |

Subscriber Eligibility: Base Stop Loss – Includes Deductible and Coinsurance

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | EB | Subscriber Eligibility or Benefit Information | | 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 | | “G” – Stop Loss |
| 2110C | EB03 | Service Type Code | | “30” – Health Benefit Plan Coverage |
| 2110C | EB05 | Plan Coverage Description | | Description of benefit plan |
| 2110C | EB06 | Time Period Qualifier | | "22" – Service Year |
| 2110C | EB07 | Monetary Amount | | Remaining Stop Loss Amount |
| 2110C | MSG | Message Text | | |
| 2110C | MSG01 | Free-form Message Text | | Will state: 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 | | 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 | | “G” – Stop Loss |
| 2110C | EB03 | Service Type Code | | “30” – Health Benefit Plan Coverage |
| 2110C | EB05 | Plan Coverage Description | | Description of benefit plan |
| 2110C | EB06 | Time Period Qualifier | | "29" – Remaining |
| 2110C | EB07 | Monetary Amount | | Stop Loss Amount |
| 2110C | MSG | Message Text | | |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | MSG01 | Free-form Message Text | | Will state: 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 | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | "1" – Active Coverage |
| 2110C | EB03 | Service Type Code | | May repeat up to 35 times for CT. Please see Appendix 6 for list of Service Type Codes. |

Subscriber Eligibility: Inactive Service Type Codes

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | "6" – Inactive |
| 2110C | EB03 | Service Type Code | | May repeat up to 35 times for CT. Please see Appendix 6 for list of Service Type Codes. |

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

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | "B" – Copay |
| 2110C | EB03 | Service Type Code | | May repeat up to 35 times for CT. Please see Appendix 6 for list of Service Type Codes. |
| 2110C | EB07 | Monetary Amount | | Copay Amount |

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

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | "A" – Coinsurance |
| 2110C | EB03 | Service Type Code | | May repeat up to 35 times for CT. Please see Appendix 6 for list of Service Type Codes. |
| 2110C | EB08 | Percent | | Coinsurance Percentage |

Other Insurance/Medicare Note: Data 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 | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | "R" – Other Or Additional Payer |
| 2110C | LS | Loop Header | | |
| 2110C | LS101 | Loop Identifier Code | | "2120" |
| 2120C | NM1 | Subscriber Benefit Related Entity Name | | |
| 2120C | NM101 | Entity Identifier Code | | "PR" – Payer |
| 2120C | NM102 | Entity Type Qualifier | | "2" – Non Person |
| 2120C | NM103 | Name Last or Organization Name | | Other Insurance Company Name |
| 2120C | NM108 | Identification Code Qualifier | | "PI" – Payer Identification |
| 2120C | NM109 | Identification Code | | Insurance Carrier Code |
| 2110C | LE | Loop Trailer | | |
| 2110C | LE01 | Loop Identifier Code | | "2120" |

Pharmacy/Lock In Information Note: Data 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 | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | "N" - Services Restricted to Following Provider |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | EB05 | Plan Coverage Description | | Description of benefit plan |
| 2110C | LS | Loop Header | | |
| 2110C | LS101 | Loop Identifier Code | | "2120" |
| 2120C | NM1 | Subscriber Benefit Related Entity Name | | |
| 2120C | NM101 | Entity Identifier Code | | "1P" – Provider |
| 2120C | NM102 | Entity Type Qualifier | | "1" – Person |
| 2120C | NM103 | Name Last or Organization Name | | Inmate Lock in / Pharmacy Last Name |
| 2120C | NM104 | Name First | | Lock in First Name |
| 2120C | NM105 | Name Middle | | Lock in Middle Initial |
| 2120C | NM108 | Identification Code Qualifier | | "XX" – National Provider Identifier |
| 2120C | NM109 | Identification Code | | NPI number |
| 2120C | PER | Subscriber Benefit Related Entity | | |
| 2120C | PER01 | Contact Function Code | | "IC" |
| 2120C | PER03 | Communication Number Qualifier | | "TE" |
| 2120C | PER04 | Communication Number | | Phone number |
| 2110C | LE | Loop Trailer | | |
| 2110C | LE01 | Loop Identifier Code | | "2120" |

Hospice/Hospital Information Note: Data 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 | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | "X" - Health Care Facility |
| 2110C | EB05 | Plan Coverage Description | | Description of benefit plan |
| 2110C | LS | Loop Header | | |
| 2110C | LS101 | Loop Identifier Code | | "2120" |
| 2120C | NM1 | Subscriber Benefit Related Entity Name | | |
| 2120C | NM101 | Entity Identifier Code | | "FA" – Facility |
| 2120C | NM102 | Entity Type Qualifier | | "1" – Person |
| 2120C | NM103 | Name Last or Organization Name | | Facility Last Name |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2120C | NM108 | Identification Code Qualifier | | "XX" – National Provider Identifier |
| 2120C | NM109 | Identification Code | | NPI number |
| 2120C | PER | Subscriber Benefit Related Entity | | |
| 2120C | PER01 | Contact Function Code | | "IC" |
| 2120C | PER03 | Communication Number Qualifier | | "TE" |
| 2120C | PER04 | Communication Number | | Phone number |

Ineligible Response

Subscriber Eligibility: Client is not eligible.

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110C | EB | Subscriber Eligibility or Benefit Information | | |
| 2110C | EB01 | Eligibility or Benefit Information Code | | "6" – Inactive |
| 2110C | EB03 | Service Type Code | | "30" – Health Benefit Plan Coverage |
| 2110C | DTP | Subscriber Date | | |
| 2110C | DTP01 | Date/Time Qualifier | | "307" – Eligibility, |
| 2110C | DTP02 | Date Time Period Format Qualifier | | "RD8" – Date Expressed as CCYYMMDD-CCYYMMDD |

| | | | | |
|---|---|---|---|---|
| 2110C | LE | Loop Trailer | | |
| 2110C | LE01 | Loop Identifier Code | | "2120" |

# 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@hp.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, Web Portal User Name and/or 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 of 270 inquiries. The actual data streams linked to these scenarios are included in the Transmission Examples section.

An eligibility request must be submitted with one of the following criteria:

1. Recipient ID and Social Security Number;
2. Recipient ID and  Date of Birth;
3. Name , Social Security Number and Date Of Birth;

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# Appendix 3. Transmission Examples

## 3.1 Inquiry by Recipient ID and Social Security number

ST*270*604493536*005010X279A1~
BHT*0022*13*604491111*20120207*0659~
HL*1**20*1~
NM1*PR*2*HP/CTMAP*****PI*75-2548221~
HL*2*1*21*1~
NM1*1P*2*NAME*****XX*9999999999~
HL*3*2*22*0~
TRN*1*604493536*8888888888~
NM1*IL*1******MI*0123456789~
REF*SY*111111111~
DTP*291*RD8*20130107-20130107~
EQ*30~
SE*13*604493536~

## 3.2 Inquiry by Recipient ID and Date Of Birth

ST*270*604493536*005010X279A1~
BHT*0022*13*604491111*20120207*0659~
HL*1**20*1~
NM1*PR*2*HP/CTMAP*****PI*75-2548221~
HL*2*1*21*1~
NM1*1P*2*NAME*****XX*9999999999~
HL*3*2*22*0~
TRN*1*604493536*8888888888~
NM1*IL*1******MI*0123456789~
DMG*D8*19821221*M~
DTP*291*RD8*20130107-20130107~
EQ*30~
SE*13*604493536~

## 3.3 Inquiry by Name, Date of Birth, and Social Security

ST*270*604493536*005010X279A1~
BHT*0022*13*604491111*20120207*0659~
HL*1**20*1~
NM1*PR*2*HP/CTMAP*****PI*75-2548221~
HL*2*1*21*1~

NM1*1P*2*NAME*****XX*9999999999~

HL*3*2*22*0~

TRN*1*604493536*8888888888~

NM1*IL*1*LAST NAME*FIRST NAME~

DMG*D8*19821221*M~

REF*SY*111111111

DTP*291*RD8*20130101-20130101~

EQ*30~

SE*14*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.List Of Service Types 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
33 Chiropractic
35 Dental Care
40 Oral Surgery
42 Home Health Care
45 Hospice
47 Hospital
48 Hospital - Inpatient
50 Hospital - Outpatient
51 Hospital - Emergency Accident
52 Hospital - Emergency Medical
53 Hospital - Ambulatory Surgical
54 – Long Term Care
56- Medically Related Trans
62 MRI/CAT Scan
65 Newborn Care
68 Well Baby Care
73 Diagnostic Medical
75- Prosthetic Device
76 Dialysis
78 Chemotherapy
80 Immunizations
81 Routine Physical
82 Family Planning
86 Emergency Services
88 Pharmacy

93 Podiatry
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
AD Occupational Therapy
AE Physical Medicine
AF Speech Therapy
AG Skilled Nursing Care
AI Substance Abuse
AL Vision (Optometry)
BG Cardiac Rehabilitation
BH Pediatric
DM – Durable Medical Equipment
MH Mental Health
PT – Physical Therapy
RT – Residential Psych Therapy
UC - Urgent Care

# Appendix 6. Benefit Messages

| Benefit Plan | Message |
|---|---|
| BHP A | Husky A. For Behavioral Health Services, call BHP at 877-552-8247. |
| BHP B | 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. |
| 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. |
| CP | Drug coverage only, under the ConnPACE Program. |
| FAMPL | Family Planning Services Only |
| FFS | Husky C. For Behavioral Health Services, call BHP at 877-552-8247. |
| MLIA | 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 7. 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 - |

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