

Geisinger Health Plan

Companion Guide for the 834 Benefit
Enrollment and Maintenance

Refers to the Implementation Guides
Based on X12 version 005010X220

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Preface

This is a Companion Guide to the ASC X12N Implementation Guides adopted under the Health Insurance Portability and Accountability Act (HIPAA). It should be used when interacting with Geisinger Health Plan (GHP). This document describes the data element requirements of GHP's trading partners for submission of EDI HIPAA compliant transactions. This guide is not meant to replace HIPAA's Implementation Guides but should be used in conjunction with them.

Disclosure Statement

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1. Introduction

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 834 Benefit Enrollment and Maintenance transaction implementation guides provide the standardized data requirements to be implemented for all electronic enrollment submissions.

The 834 transaction is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. Only sponsors that have been deemed “covered entities” are required to use the ANSI X12N 834 transaction.

1.1 Scope

This Companion Guide explains the procedures necessary for trading partners of the Health Plan to transmit Electronic Data Interchange (EDI) for the 834 Benefit Enrollment and Maintenance transaction. This Companion Guide is not intended to replace, contradict or exceed the X12N Implementation Guides; rather it is intended to be used in conjunction with them.

1.2 Overview

The first part of this Companion Guide explains its purpose and the trading partner’s role in working with the Health Plan. It also provides important information on the communication process and detailed Health Plan contact information.

1.3 References

This Companion Guide should be used in conjunction with the Implementation Guides, which can be obtained from the Washington Publishing Company on their web site at <http://www.wpc-edi.com/content/view/817/1>.

Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – <http://www.wedi.org>

United States Department of Health and Human Services (DHHS) – <http://aspe.hhs.gov/admsimp/>

Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.hhs.gov/HIPAAGenInfo/>

Designated Standard Maintenance Organizations (DSMO) – <http://www.hipaa-dsmo.org/>

National Council of Prescription Drug Programs (NCPDP) – <http://www.ncdp.org/>

National Uniform Billing Committee (NUBC) – <http://www.nubc.org/>

Accredited Standards Committee (ASC X12) – <http://www.x12.org/>

2. Certification and Testing Overview

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types of HIPAA compliance testing, these are:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax and compliance with X12 rules.
2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.
3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.
4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.
5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.
6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.
7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid and Indian Health. Compliance testing with these payer specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

3. Connectivity / Communications

The Health Plan has a communication server with secure internet access for transmitting and receiving EDI transactions. Please contact our EDI Technical Contact listed in Section 4 for the account set up and software requirements.

4. Contact information

4.1 Health Plan Enrollment Services

If you have any questions or need additional EDI information, please contact the Health Plan's Information Technology Department at the following:

Contact Name:
EDI Technical Contact
100 N. Academy Avenue
Danville, PA, 17822-3233

Telephone: 570-271-5633
Fax: 570-271-5162
Weekdays 8:30am – 5:00pm.

If you have any questions or need additional enrollment processing information, please contact the Health Plan's Enrollment Department at the following:

Enrollment Manager
100 N. Academy Avenue
Danville, PA, 17822-3229

Telephone: 570-271-5555 x. 52759
Fax: 570-271-5516
Weekdays 8:00am – 5:00pm.

4.2 Available Websites

For on-line EDI information, including the Health Plan's companion guides, access <http://www.thehealthplan.com/bottomnav/hipaa.cfm>

5. Payer Business Rules and Limitations

5.1 Headers

ISA

Interchange Control Header

Loop: N/A

To start and identify an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>
ISA05	I05	Interchange ID Qualifier	M	ID	2/2
		<u>Code</u> <u>Name</u>			
		ZZ Mutually Defined			
ISA06	I06	Interchange Sender ID	M	AN	15/15
ISA07	I07	Interchange ID Qualifier	M	ID	2/2
		<u>Code</u> <u>Name</u>			
		30 U.S. Federal Tax Identification Number			
ISA08	I08	Interchange Receiver ID	M	AN	15/15

The Health Plan prefers the Interchange Control Header required data elements to be formatted in the ISA segment as follows:

ISA05 is set to ZZ (Mutually Defined)

ISA06 is set to the Health Plan's assigned or mutually agreed upon sender identification number

ISA07 is set to 30 (U.S. Federal Tax Identification Number)

ISA08 is set to the Health Plan's U.S. Federal Tax Identification Number of 23-2311553

GS

Functional Group Header

Loop: N/A

To indicate the beginning of a functional group and to provide control information.

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>
GS03	124	Application Receiver's Code	M	AN	2/15

The Health Plan prefers the Functional Group Header required data elements to be formatted in the GS segment as follows:

GS03 is set to the Health Plan's U.S. Federal Tax Identification Number of 23-2311553

5.2 Detail

N1

Payer

Loop: 1000B

To identify a party by type of organization, name, and code

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>
N103	66	Identification Code Qualifier	X	ID	1/2
		<u>Code</u> <u>Name</u>			
		FI Federal Taxpayer's Identification Number			
N104	67	Identification Code	X	AN	2/80

The Health Plan requires one (1) "Payer" segment to be formatted in the N1 segment as follows:

N103 is set to FI (Federal Taxpayer's Identification Number)

N104 is set to the Health Plan's Federal Taxpayer's Identification Number of 23-2311553

REF

Member Policy Number

Loop: 2000

To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3
		<u>Code</u> <u>Name</u>			
		1L Group or Policy Number			
REF02	127	Reference Identification	X	AN	1/30

The Health Plan requires one (1) "Member Policy Number" segment to be formatted in the REF segment as follows:

REF01 is set to 1L (Group or Policy Number – the Health Plan's Group/Division number)

REF02 is set to the Health Plan's Group/Division number

DTP

Member Level Dates

Loop: 2000

To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Reg</u>	<u>Type</u>	<u>Min/Max</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3
		<u>Code</u> <u>Name</u>			
		336 Employment Begin			
DTP03	1251	Date Time Period	M	AN	1/35

The Health Plan requires one (1) "Member Level Dates" segment when a new subscriber is enrolled. It needs to be formatted in the DTP segment as follows:

DTP01 is set to 336 (Employment Begin)
 DTP03 is set to the subscriber's employment begin date

NM1

Member Name

Loop: 2100A

To specify identifying information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Reg</u>	<u>Type</u>	<u>Min/Max</u>
NM108	66	Identification Code Qualifier	X	ID	1/2
		<u>Code</u> <u>Name</u>			
		34 Social Security Number			
NM109	67	Identification Code	X	AN	2/80

The Health Plan prefers one (1) "Member Name" segment to be formatted in the NM1 segment as follows:

NM108 is set to 34 (Social Security Number)
 NM109 is set to the Member's Social Security Number

If trading partner does not have Member's Social Security Number do not send NM108 and NM109.

6. Acknowledgements and or Reports

6.1 Report Inventory

The Health Plan supports the following response acknowledgement to the 834 Benefit Enrollment and Maintenance Transaction upon request:

- 997 Functional Acknowledgement
- Proprietary Detailed Error Reporting

Appendix Summary of Changes

Date of Change: 10/28/2010 – Version 1.0 Original Document