State of Washington
Companion Guide
To the
Accredited Standards Committee (ASC)
X12
Technical Report Type 3 (TR3)
834 Benefit Enrollment and Maintenance
Based On Version 005010X220A1

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This companion guide contains data clarifications derived from specific business rules that apply exclusively to Washington State Medicaid processing for Washington State HCA. The guide also includes useful information about receiving data from the Washington State ProviderOne system.

Revision History

Documented revisions are maintained in this document through the use of the Revision History Table shown below. All revisions made to this companion guide after the creation date are noted along with the date, page affected, and reason for the change.

Revision Level	Date	Page	Description	Change Summary
WAMMIS-CG834-5010-01-01	12/15/2010		Initial Document	
WAMMIS-CG834-5010-01-02	03/01/2012		Version number updated due to the inclusion of full Companion Guide Boilerplate information	
WAMMIS-CG834-5010-01-03	04/2014		Updated per ASC X12 recommendations	
WAMMIS-CG834-5010-01-04	05/19/16		Updated to include comprehensive reason code list MCO and RSN delivery schedule changed to reflect 2016 HD and DTP segment update in regards to Living Arrangement and Institutional Code scenarios	
WAMMIS-CG834-5010-01-05	06/01/2017		Updated to reflect new Transaction Reason, Maintenance Type & Maintenance Reason Codes Enrollment • Transaction Reason SO – Incarceration/Suspension Override • Maintenance Type 21 • Maintenance Reason 28 Disenrollment • IS – Incarceration/Suspension • Maintenance Type 24 • Maintenance Reason 18	

WAMMIS-CG834-5010-01-06	10/20/2017		Updated to reflect new Transaction Reason, Maintenance Type & Maintenance Reason Code Change Transaction • IM – Institution for Mentally Diseased • Maintenance Type 001 • Maintenance Reason AI	
WAMMIS-CG834-5010-01-07	12/15/2017		Update to reflect new additional usage of the repeated HD Segment to provide Foundational Community Support elements when appropriate. MCO and BHO report schedule updated to reflect 2018	
WAMMIS-CG834-5010-01-08	06/01/2018		Updated to reflect new Transaction Type, Transaction Reason, Maintenance Type & Maintenance Reason Code Disenrollment • RM – Medicare Part A/B/C • Maintenance Type 024 • Maintenance Reason 14	
WAMMIS-CG834-5010-01-09	11/19/2018		Updated to reflect new DDE Indicator Y = Yes N = No E = Develop Disabled Special Services	
WAMMIS-CG834-5010-01-10	12/26/2018		MCO and BHO report schedule updated to reflect 2019	

WAMMIS-CG834-5010-01-11	01/22/2020		MCO and BHO report schedule updated for 2020 and PONE Screen prints	
WAMMIS-CG834-5010-01-12	12/9/2021		Update to reflect new additional usage of the repeated HD Segment to provide Client Incarceration Location when appropriate.	
WAMMIS-CG834-5010-01-13	01/08/2023		Update to reflect new additional usage of the repeated HD Segment to provide Community BH Services indicator. MCO and BHO report schedule updated to reflect 2023	
WAMMIS-CG834-5010-01-14	04/28/2023		Update to reflect new additional usage of the repeated HD Segment to provide Eligibility End Reason code.	
WAMMIS-CG834-5010-01-15	2/24/2025		Update logos and formatting	

Contents

1 Introduction

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) includes requirements that national standards be established for electronic health care transactions, and national identifiers for providers, health plans, and employers. This requires Washington State Health Care Authority (HCA) to adopt standards to support the electronic exchange of administrative and financial health care transactions between covered entities (health care providers, health plans, and healthcare clearinghouses).

The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care. The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were developed by processes that included significant public and private sector input.

1.1 Document Purpose

Companion Guides are used to clarify the exchange of information on HIPAA transactions between the HCA ProviderOne system and its trading partners. HCA defines trading partners as covered entities that either submit or retrieve HIPAA batch transactions to and from ProviderOne.

This Companion Guide provides information about the 834 Enrollment file that is specific to HCA and HCA trading partners. It will include both the 834 Audit and 834 Update. This Companion Guide is intended for trading partner use in conjunction with the ASC X12 TR3 834 Benefit Enrollment and Maintenance version 005010X220A1. The ASC X12 TR3s that detail the full requirements for all HIPAA mandated transactions are available at http://store.x12.org/store/.

1.1.1 Intended Users

Companion Guides are intended for members of the technical staffs of trading partners who are responsible for electronic transaction/file exchanges.

1.1.2 Relationship to HIPAA Implementation Guides

Companion Guides are intended to supplement the ASC X12 TR3 HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This Companion Guide describes the technical interface environment with HCA, including connectivity requirements and protocols, and electronic interchange procedures. This guide also provides specific information on data elements and the values required for transactions sent to or received from HCA.

Companion Guides are intended to supplement rather than replace the ASC X12 TR3 for each transaction set. The information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

1.2 Transmission Schedule

The 834 audit files will be posted a day after the Medicaid Enrollment Cut-Off Date. The 834 daily update files will be posted after 12 AM PST.

2 Technical Infrastructure and Procedures

2.1 Technical Environment

2.1.1 Communication Requirements

This section will describe how trading partners will receive 834 Transactions from HCA using two methods:

- Secure File Transfer Protocol (SFTP)
- ProviderOne Web Portal

2.1.2 Testing Process

Completion of the testing process must occur prior to production electronic retrieval from ProviderOne. Testing is conducted to ensure the following for maintaining HIPAA guidelines:

1. Syntactical integrity: Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 or NCPDP syntax, and compliance with X12 and NCPDP rules.
2. Syntactical requirements: Testing for HIPAA Implementation Guide specific syntax requirements (such as limits on repeat counts), qualifiers, codes, elements and segments. This process should also include testing for HIPAA required or situational data elements, medical code sets, and values and codes noted in the Implementation Guide via an X12 code list or table.

Additional testing may be required in the future to verify any changes made to the ProviderOne system. Changes to the formats may also require additional testing. Assistance is available throughout the testing process.

Trading Partner Testing Procedures

1. ProviderOne companion guides and trading partner enrollment package are available for download via the web at http://www.hca.wa.gov/medicaid/hipaa/Pages/index.aspx
2. The Trading Partner completes the Trading Partner Agreement and submits the signed agreement to HCA.

   Submit to: HCA HIPAA EDI Department
   626 8th Avenue SE
   PO Box 45564
   Olympia, WA 98504-5564

**For Questions call 1-800-562-3022

3. The trading partner is assigned a Submitter ID, Domain, Logon User ID and password.
4. ProviderOne system processes and validates all outbound HIPAA test files. It will be available for download via the ProviderOne web portal or Secure File Transfer Protocol (SFTP).
    - Web Portal URL: https://www.waproviderone.org/edi
    - SFTP URL: sftp://ftp.waproviderone.org/
5. The trading partner downloads the file from the ProviderOne web portal or Secure File Transfer Protocol (SFTP).
6. If the test file download is successful and the trading partner's system accepts the file for processing, the trading partner is approved for transaction download in the ProviderOne production environment.
7. If the test file download is unsuccessful, the trading partner should immediately email HIPAA-help@HCA.wa.gov to report the failure. Testing will continue in the test environment until a successful download is completed.

2.1.3 Who to contact for assistance

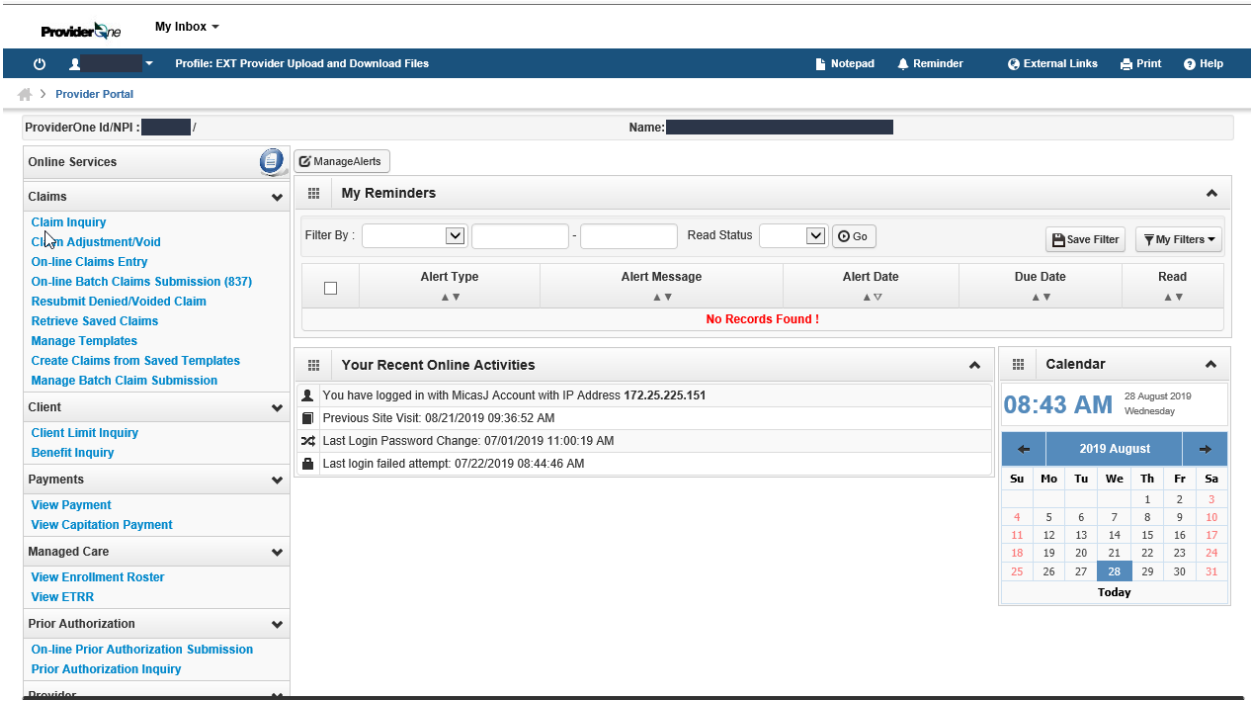
Email: hipaa-help@hca.wa.gov

- All emails result in the assignment of a Ticket Number for problem tracking

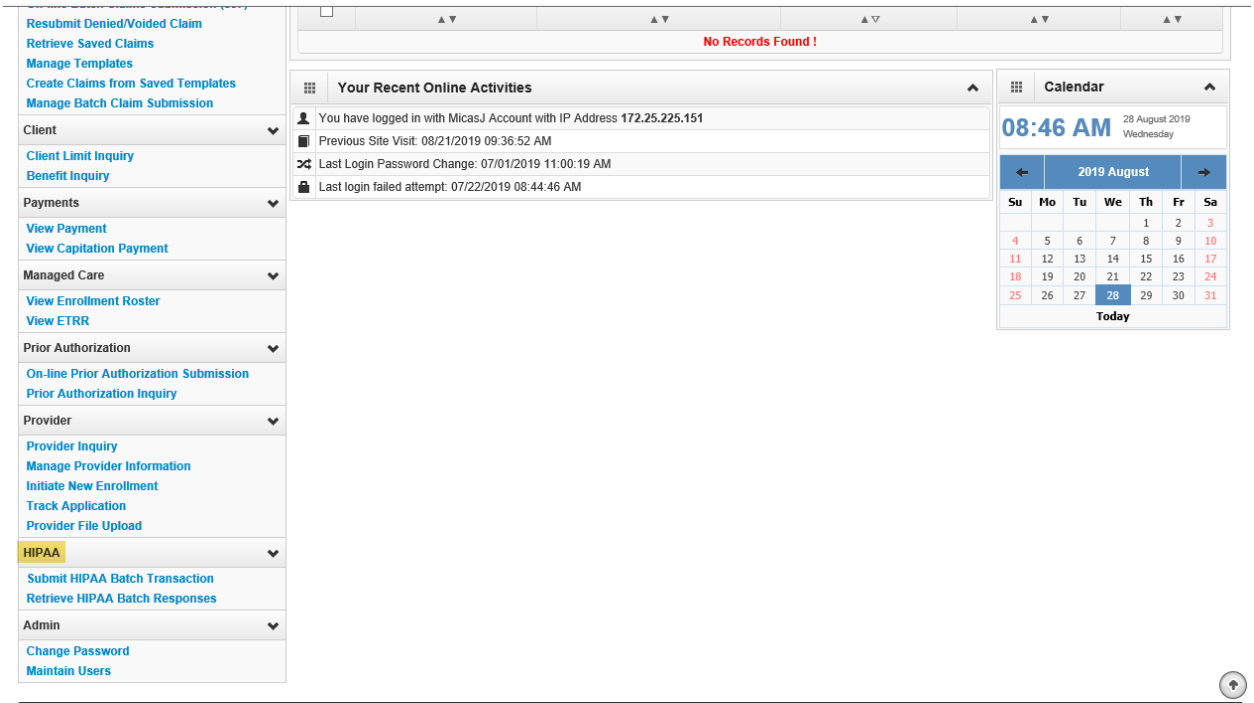
- Information required for initial email:
    - Name
    - Phone Number
    - Email Address
    - 7-digit domain/ProviderOne ID
    - Transaction you are inquiring about
    - File Name
    - Detailed description of the concern
- Information required for follow up:
    - Assigned Ticket Number

2.2 Retrieve batches via Web Interface

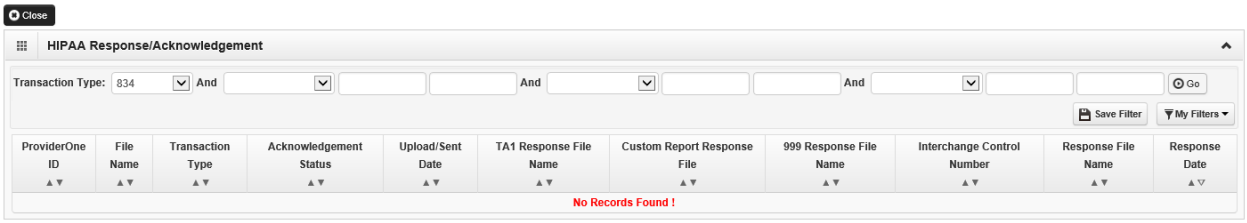
Log into the ProviderOne Portal, select the appropriate security profile and the following options will be presented to the user:



Scroll down to the HIPAA heading to manage the submission and retrieval of HIPAA transactions.



Select Retrieve HIPAA Batch Responses option from the main screen to retrieve HIPAA Outbound files (TA1, 999, 271, 277, 820, 834, 835, 277U) as shown below:



2.3 Set-up, Directory, and File Naming Convention

2.3.1 SFTP Set-up

Trading partners can contact hipaa-help@hca.wa.gov for information on establishing connections through the SFTP server. Upon completion of set-up, they will receive additional instructions on SFTP usage.

2.3.2 SFTP Directory Naming Convention

There would be two categories of folders under Trading Partner's SFTP folders:

1. **TEST – Trading Partners should submit and receive their test files under this root folder**
2. **PROD – Trading Partners should submit and receive their production files under this root folder**
3. **README – This folder will include messages regarding password update requirements, outage information and general SFTP messages.**

Following folder will be available under TEST/PROD folder within SFTP root of the Trading Partner:

'HIPAA_Inbound' - This folder should be used to drop the Inbound files that needs to be submitted to HCA

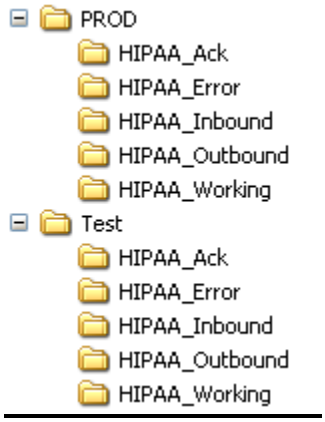
'HIPAA_Ack' - Trading partner should look for acknowledgements to the files submitted in this folder. TA1, 999 and custom error report will be available for all the files submitted by the Trading Partner

'HIPAA_Outbound' – X12 outbound transactions generated by HCA will be available in this folder

'HIPAA_Error' – Any inbound file that is not HIPAA compliant or is not recognized by ProviderOne will be moved to this folder

'HIPAA Working' – There is no functional use for this folder at this time

Folder structure will appear as:



2.3.3 File Naming Convention

HIPAA files are named in the following format.

For Outbound transactions:

HIPAA.<TPId>.<datetimestamp>.<TxID>.O.<out>

Example of file name: HIPAA.123456700.12262007211315.834.O.out

- <TPId> is the Trading Partner Id
- <datetimestamp> is the Date timestamp
- <TxID> is the Transaction Id.

2.4 Transaction Standards

2.4.1 General Information

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. Currently, the 834 Enrollment and Maintenance has one Addendum. This Addendum has been adopted as final and is incorporated into HCA requirements.

The ASC X12 TR3 834 Benefit and Enrollment Maintenance contains information related to:

- Format and content of interchanges and functional groups

- Format and content of the header, detail and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

Transmission sizes are limited based on two factors:

- Number of Segments/Records allowed by HIPAA standards
- HCA file transfer limitations

HCA has no size limitations for postings to its SFTP Server.

2.4.2 Data Format

Delimiters

The ProviderOne will use the following delimiters on outbound transactions:

- Data element separator, Asterisk, (*)
- Sub-element Separator, Vertical Bar, (:)
- Segment Terminator, Tilde, (~)
- Repetition Separator, Caret, (^)

2.4.3 Data Interchange Conventions

When transmitting 834 transactions, HCA follows standards developed by ASC X12. These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or “outer envelopes”. All 834 transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B1 of the ASC X12 TR3 834 Implementation Guide. Specific information on how individual data elements are populated by HCA on ISA/IEA and GS/GE envelopes are shown in the table beginning later in this section.

HCA transmits 834 Transaction files with single ISA/IEA and GS/GE envelope. 834 Transactions will have 10,000 members per ST-SE segment and may have multiple transaction sets within the same GS/GE envelope.

2.4.4 Acknowledgement Procedures

N/A

2.4.5 Rejected Transmissions and Transactions

HCA will validate all 834 transactions up to HIPAA validation levels 1 and 2. If a receiver rejects any part of a transmission, they must reject the entire transmission. Data on rejected 834 transmissions should not be used to update receiver's databases as HCA will resend a corrected full-file replacement. HCA transmits 834 Transactions within a single functional group, even when multiple transactions (ST through SE Segments) are required.

3 Transaction Specifications

Page	Loop	Segment	Data Element	Element Name	Comments
Interchange Control Header					
App. C	Header	ISA	01	Authorization Information Qualifier	This field will be populated with '00' – No Authorization information.
App. C	Header	ISA	03	Security Information Qualifier	This field will be populated with '00' – No Security information.
App. C	Header	ISA	05	Interchange ID Qualifier	This field will be populated with 'ZZ'.
App. C	Header	ISA	06	Interchange Sender ID	This field will be populated with '77045'- WA State DSHS Sender ID
App. C	Header	ISA	07	Interchange ID Qualifier	This field will be populated with 'ZZ'
App. C	Header	ISA	08	Interchange Receiver ID	This field will be populated with the 9 Digit ProviderOne ID of the receiver.
App. C	Header	ISA	11	Repetition Separators	Use ^ for repetition separator.
App. C	Header	ISA	16	Component Element Separator	This field will be populated with Value = ":"
Functional Group Header					
App. C	Header	GS	02	Application Sender's Code	This field will be populated with '77045' - WA State DSHS Sender ID
App. C	Header	GS	03	Application Receiver's Code	This field will be populated with the 9 Digit ProviderOne ID of the receiver.

Beginning Segment					
32	Header	BGN	01	Transaction Set Purpose Code	'00' – Original. Copy of the original will be available from archive.
33	Header	BGN	02	Reference Identification	This field will be populated with the Sender's Reference Number
35	Header	BGN	08	Action Code	Values to be received: '2' = Change (Update) '4' = Verify (Audit)
Transaction Set Policy Number Segment					
36	Header	REF	02	Reference Identification	This filed will be populated with the 9-digit ProviderOne Health Plan Provider ID Number (1st 7 digits – numeric, last 2 digits – alpha-numeric) e.g. 1234567AA, 567895401
Sponsor Name					
39	1000A	N1	02	Name	This field will be populated with 'WA State DSHS'
40	1000A	N1	04	Identification Code	This field will be populated with '91-6001088'.
Payer Name					
41	1000B	N1	02	Name	This field will be populated with the Payer Name (i.e. Columbia United Providers; Molina, Regence etc.)
42	1000B	N1	04	Identification Code	This field will be populated with the Payer Tax-ID/Employer Identification Number
Subscriber Identifier					

55	2000	REF	02	Reference Identification	This field is populated with Medicaid ProviderOne Client Identification Number in the following format. 9-digit numeric and 2-digit alpha. e.g. 123456789WA
Member Policy Number					
56	2000	REF	02	Reference Identification Number	This field will be populated with the 9-digit ProviderOne Health Plan Provider ID Number (1st 7 digits – numeric, last 2 digits – alpha-numeric) e.g. 1234567AA , 567895401
Member Supplemental Identifier					
57-58	2000	REF	01	Reference Identification Qualifier	Recipient Identification Qualifier ‘23’ ‘3H’ 'ZZ' ‘Q4’ '17' (when available) ‘DX’ (when applicable) Note: WA State Medicaid will only report the five qualifiers above. The qualifiers will also be reported in the order as referenced above.

Member Level Dates					
59	2000	DTP			Refer to section 4 “Reporting of Dates in the 834” for the dates reported for each maintenance type code.
Member Name					
64	2100A	NM1	09	Identification Code	This field is populated with the Medicaid Client’s Social Security Number (when available).
Member Residence City, State, Zip Code					
69	2100A	N4	06	Location Identifier	Populated with the Rate Region Code
Incorrect Member Name					
87	2100B	NM1	09	Identification Code	Prior incorrect insured Social Security Number (when available).

Custodial Parent					
114	2100F	NM1			NOTE: Will be used to retain the name of a newborn's mother.
116	2100F	NM1	09	Identification Code	Mother's Social Security Number (when available).
Responsible Person					
123	2100G	NM1			Note: Will be used to report the head of household information
125	2100G	NM1	09	Identification Code	Head of household Social Security Number (When available).
Health Coverage					
141	2300	HD	04	Plan Coverage Description	This data element has 50 characters and is coded as follows: Rate Cohort Combination (5 N) Premium Determinant RAC (4 AN) Medicare Status (2 AN) *Pregnancy Due Date (8 N (MMDDYYYY)) *Self-Assessment (1 AN) *Special Needs Indicator (1 AN) Surgery Date (8 N (MMDDYYYY)) Recertification Date

					(8 N (MMDDYYYY)) PRR Indicator (1 AN) Client Exception Indicator (1 AN) Expected Delivery Date (8 N (MMDDYYYY)) Transaction Reason (2 AN) Health Home Clinical Indicator (1 AN) *'*' Identifies Data collected from Client Enrollment Form*
141	2300	HD	04	Plan Coverage Description	The HD segment will repeat to provide Living Arrangement, Institutional Status, Foundational Community Support, and Developmental Disability Enrolled information as available. This data element has 50 characters and will be coded as follows: Living Arrangement (2 AN) Institutional Status (2 AN) Foundational Community Supports (1 A)

					Developmental Disability Enrolled (1A) Location Code (3N) Community BH Services indicator (1A) End Reason Code (2 AN)
Health Coverage Dates					
143	2300	DTP			Please refer section 4 “Reporting of Dates in the 834” for the dates reported for each maintenance type code. This DTP segment will repeat if Living Arrangement or Institutional Status information is available.
144	2300	DTP	03	Date Time Period	CCYYMMDD Date Plan Coverage Begins/Ends in Update file or first day of the Month (for which premium info is being sent) in the Audit file.
Provider Name					
155	2310	NM1	09	Identification Code	This field will be populated with the Provider NPI. If the NPI is not available, the Provider information will be populated in NM103, NM104, NM105.

Coordination of Benefits Related Entity					
170	2330	NM1	NM109	Identification Code	This field will be populated with the Federal Taxpayer's Identification Number of the COB Payer (if available).

4 Reporting of Dates in the 834

Dates reported on the 834 will vary based on the type of file being sent, i.e. Audit or Update. Within the Update file the dates reported will vary dependent upon the nature of the transaction, i.e. enrollment, disenrollment, change to coverage, or a demographic change that does not impact coverage. Please see the table below for a detailed definition of usage.

Monthly 834 Audit File				
Transaction Type	**Maintenance Type Code**	**Loop, Segment,**	**Date Qualifier**	**Notes**
Audit	'030' Audit	Loop 2000, DTP01	Not Reported	Loop 2000 Member level dates are not returned on an Audit File
Audit	'030' Audit	Loop 2300, DTP01	'303' – Transaction Effective Date	'303' is first day of reporting period, and is reported only when the member is reported on the previous months Audit File
Audit	'030' Audit	Loop 2300, DTP01	'348' – Health Plan Coverage Begin Date	'348' is used on an Audit File to report Health Plan Coverage Begin date
Audit	'030' Audit	Loop 2300, DTP01	'349' – Health Plan	'349' is used on an Audit File when member

			Coverage End Date	coverage ends in Audit reporting month.

Monthly 834 Update File				
Transaction Type	**Maintenance Type Code**	**Loop, Segment,**	**Date Qualifier**	**Notes**
Change impacting coverage	'001' Change (Change that impacts Coverage)	Loop 2000, DTP01	'473' – Medicaid Eligibility Begin Date	'473' will be used at Loop 2000 Member Level Date to pass the member's Medicaid eligibility begin date.
Change impacting coverage	'001' Change (Change that impacts Coverage)	Loop 2000, DTP01	'474' – Medicaid Eligibility End Date	For change effecting coverage '474' will be used at Loop 2000 Member level date to pass Member Medicaid Eligibility End date.
Change impacting coverage	'001' Change (Change that impacts Coverage)	Loop 2300, DTP01	'303' - Transaction Effective Date	'303' is used on an Update File at Loop 2300 Health Coverage Level Dates to identify the actual date of change in coverage.

Change impacting coverage	'001' Change (Change that impacts Coverage)	Loop 2300, DTP01	'348' – Health Plan Coverage Begin Date	'348' is used on an Update File at Loop 2300 Health Coverage Level Dates to provide begin date of new coverage or the updated Health plan coverage begin date.
Change impacting coverage	'001' Change (Change that impacts Coverage)	Loop 2300, DTP01	'349' – Health Plan Coverage End Date	For change effecting coverage '349' will be used at Loop 2300 Health Coverage Level Date to pass the member's Health Plan coverage end date.
Change that does not impact coverage	'001' Change (Change that does not impact Coverage)	Loop 2000, DTP01	'303' – Transaction Effective Date	'303' is used on an Update File at Loop 2000 Member level dates to identify the actual date of change that does not impact coverage
Change that does not impact coverage	'001' Change (Change that does not impact Coverage)	Loop 2300, DTP01	Not Reported	When reporting a change that does not impact coverage, Loop 2300 is not returned per the IG.

Enrollment	'021' Addition	Loop 2000, DTP01	'473' – Medicaid Eligibility Begin Date	For new enrollees '473' will be used at Loop 2000 Member Level Date to pass the member's Medicaid eligibility begin date
Enrollment	'021' Addition	Loop 2000, DTP01	'474' – Medicaid Eligibility End Date	For new enrollees '474' will be used at Loop 2000 Member level date to pass Member Medicaid Eligibility End date.
Enrollment	'021' Addition	Loop 2300, DTP01	'348' – Health Plan Coverage Begin Date	For new enrollees '348' will be used at Loop 2300 Health Coverage Level Date to pass the member's Health Plan Coverage eligibility begin date
Enrollment	'021' Addition	Loop 2300, DTP01	'349' – Health Plan Coverage End Date	For new enrollees '349' will be used at Loop 2300 Health Coverage Level Date to pass the member's Health Plan Coverage eligibility end date

Disenrollment	'024' Termination	Loop 2000, DTP01	'474' – Medicaid Eligibility End Date	Loop 2000 Member level date will only be used when the termination of eligibility with the plan is due to loss of Medicaid eligibility – otherwise Loop 2000 Member level dates will not be populated on disenrollments.
Disenrollment	'024' Termination	Loop 2300, DTP01	'349' – Health Plan Coverage End Date	For disenrollments '349' will be used at Loop 2300 Health Coverage Level Date to pass the member's Health Plan coverage end date.

5 MCO reporting schedule

2025 Reporting Schedule for all Medical Programs												
Coverage Period												
Reporting Transaction	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Enrollment Cut-off	1/30	2/27	3/30	04/29	05/30	06/29	07/30	08/30	09/29	10/30	11/29	12/30
834 Audit/820 Full Payment Generation	1/26	2/23	3/30	4/27	5/25	6/22	7/27	8/24	9/28	10/26	11/23	12/28
Daily 834 Update - 820 Interim Payment Generation	1/6	2/3	3/3	4/7	5/5	6/2	7/7	8/4	9/1	10/6	11/3	12/1
Daily 834 Update – 820 Interim Payment Generation	1/13	2/10	3/10	4/14	5/12	6/9	7/14	8/11	9/8	10/13	11/10	12/8
Daily 834 Update – 820 Interim Payment Generation	1/20	2/17	3/17	4/21	5/19	6/16	7/21	8/18	9/15	10/20	11/17	12/15
Daily 834 Update – 820 Interim Payment Generation	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9/22	N/A	N/A	12/22
Last Business (Calendar) Day Reporting	1/31	2/28	3/31	4/30	5/31	6/30	7/31	8/31	9/30	10/31	11/30	12/31

6 BHO reporting schedule

2025 Reporting Schedule for all BHO Programs												
Coverage Period												
Reporting Transaction	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Enrollment Cut-off	1/30	2/27	3/30	04/29	05/30	06/29	07/30	08/30	09/29	10/30	11/29	12/30
834 Audit/820 Full Payment Generation	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Weekly 834 Update/820 Interim Payment Generation	1/06	2/03	3/03	4/07	5/05	6/02	7/07	8/04	9/01	10/06	11/03	12/01
Weekly 834 Update/820 Interim Payment Generation	1/13	2/10	3/10	4/14	5/12	6/09	7/14	8/11	9/08	10/13	11/10	12/8
Weekly 834 Update/820 Interim Payment Generation	1/20	2/17	3/17	4/21	5/19	6/16	7/21	8/18	9/15	10/20	11/17	12/15
Weekly 834 Update/820 Interim Payment Generation	1/27	2/24	3/24	4/28	5/26	6/23	7/28	8/25	9/22	10/27	11/24	12/22
Weekly 834 Update/820 Interim Payment Generation	N/A	N/A	3/31	N/A	N/A	6/30	N/A	N/A	9/29	N/A	N/A	N/A
Last Business Day Reporting	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix A - Maintenance Reason Codes

Transaction Type	Transaction Reason Code	Transaction Reason Code Description	Maintenance Type Code	Maintenance Reason Code	Maintenance Reason Description
1-Enrollment	AA	Auto Assignment	021	28	Initial Enrollment
	BH	BHP+ Enrollment	021	28	Initial Enrollment
	CC	Client Choice	021	EC	Member Benefit Selection
	CS	County Status Change	021	28	Initial Enrollment
	DE	Duplicate Client Record	021	28	Initial Enrollment
	EF	External File - Plan Initiated	021	28	Initial Enrollment
	HA	Health Home Assignment	021	28	Initial Enrollment
	IP	Internal Process/Audit	021	28	Initial Enrollment
	IT	Internal Transfer	021	28	Initial Enrollment
	L1	Enrollment Reconnect	021	28	Initial Enrollment
	L5	Re-enrollment with 2 months	021	41	Re-Enrollment
	L6	Newborn Enrollment - prspctv	021	28	Initial Enrollment
	L7	Re-enrollment within 6-12 months	021	41	Re-enrollment

Transaction Type	Transaction Reason Code	Transaction Reason Code Description	Maintenance Type Code	Maintenance Reason Code	Maintenance Reason Description
	MD	Newborn - Mom in diff. plan	021	22	Plan Change
	MM	BHP+ Mismatch	021	28	Initial Enrollment
	MP	Multiplan	021	28	Initial Enrollment
	NB	Newborn Enrollment - prspctv	021	28	Initial Enrollment
	NP	New Program	021	28	Initial Enrollment
	NR	Newborn Enrollment - rtrspctv	021	28	Initial Enrollment
	OC	Plan Ownership Change	021	28	Initial Enrollment
	OE	Open Enrollment	021	28	Initial Enrollment
	PC	Program Change	021	28	Initial Enrollment
	PM	Program Manager	021	28	Initial Enrollment
	PR	Previous Provider Re-connect	021	28	Initial Enrollment
	PT	Plan Termination	021	28	Initial Enrollment
	QQ	Contract Change	021	28	Initial Enrollment
	RI	Re-instatement	025	41	Re-Enrollment
	SA	Service Area Change	021	28	Re-Enrollment

Transaction Type	Transaction Reason Code	Transaction Reason Code Description	Maintenance Type Code	Maintenance Reason Code	Maintenance Reason Description
	SO	Incarceration/ Suspension Override	021	28	Initial Enrollment
	TA	TBQ Assignment	021	28	Initial Enrollment
	XA	Extended Auto Assignment	021	28	Initial Enrollment
	XB	Extended Reenrollment or Reinstatement	021	28	Initial Enrollment
	XC	Extended Client Choice enrollment	021	28	Initial Enrollment
	XL	Plan not available	021	28	Initial Enrollment
	XP	Program not available	021	28	Initial Enrollment
	XR	Automatic Reinstatement	025	41	Re-Enrollment
2-Disenrollment	01	AI/AN	024	14	Voluntary Withdrawal
	02	Homeless	024	14	Voluntary Withdrawal
	06	Inpatient Drg Trtmnt Facil	024	14	Voluntary Withdrawal
	12	TPL - PHIPP	024	14	Voluntary Withdrawal
	13	TPL- Employer Paid Premiums	024	14	Voluntary Withdrawal
	17	Limited English	024	14	Voluntary Withdrawal
	19	Voluntary Program	024	14	Voluntary Withdrawal

Transaction Type	Transaction Reason Code	Transaction Reason Code Description	Maintenance Type Code	Maintenance Reason Code	Maintenance Reason Description
	1A	Birth Date Missing	024	33	Personnel Data
	1B	Birth Date Invalid	024	33	Personnel Data
	1C	Gender Code Invalid	024	33	Personnel Data
	1D	RAC not Eligible for Managed Care	024	07	Termination Of Benefits
	1E	Residence Zip Code Missing	024	33	Personnel Data
	1F	Residence Zip Code Invalid	024	33	Personnel Data
	1G	No Programs in Residential Zip Code	024	07	Termination Of Benefits
	1H	No MCOs or Plans in Residential Zip Code	024	07	Termination Of Benefits
	1J	Previously enrolled plan not available	024	XT	Transfer
	1K	HOH Missing	024	33	Personnel Data
	20	Plan Initiated	024	14	Voluntary Withdrawal
	22	Hospice	024	14	Voluntary Withdrawal
	24	Loss of Eligibility	024	07	Termination Of Benefits
	25	Exception to Policy	024	07	Termination Of Benefits
	26	LTC K01 Program	024	07	Termination Of Benefits
	27	Purdy Child	024	07	Termination Of Benefits

Transaction Type	Transaction Reason Code	Transaction Reason Code Description	Maintenance Type Code	Maintenance Reason Code	Maintenance Reason Description
	28	Other	024	14	Voluntary Withdrawal
	4A	Foster Care	024	14	Voluntary Withdrawal
	4B	Adoption/ Alumni	024	14	Voluntary Withdrawal
	7A	Out of Service Area - Plan	024	14	Voluntary Withdrawal
	7B	Out of Srvc Area - Client	024	14	Voluntary Withdrawal
	8A	Medical Determination	024	14	Voluntary Withdrawal
	8B	Medical Prvdr Not Avail.	024	14	Voluntary Withdrawal
	8C	Pharmaceutical Concern	024	14	Voluntary Withdrawal
	8D	DOC Incarcerated or Special Facility	024	14	Voluntary Withdrawal
	8E	Svc - Qual of Care Concern	024	14	Voluntary Withdrawal
	8F	Medical Provider Available	024	14	Voluntary Withdrawal
	8G	Non-medical Srvc Concern	024	14	Voluntary Withdrawal
	8H	Nrsng Home Prvdr Not Avail	024	14	Voluntary Withdrawal
	8I	Nursing Home LTC	024	14	Voluntary Withdrawal

Transaction Type	Transaction Reason Code	Transaction Reason Code Description	Maintenance Type Code	Maintenance Reason Code	Maintenance Reason Description
	8L	Provider Concern	024	14	Voluntary Withdrawal
	91	High Risk Pregnancy - 1st	024	14	Voluntary Withdrawal
	92	High Risk Pregnancy - 2nd	024	14	Voluntary Withdrawal
	93	High Risk Pregnancy - 3rd	024	14	Voluntary Withdrawal
	AL	Undocumented citizen	024	07	Termination Of Benefits
	AR	Assignment Retracted	024	07	Termination Of Benefits
	BH	BHP+ Enrollment	024	07	Termination Of Benefits
	CC	Client Choice	024	14	Voluntary Withdrawal
	CD	Client Deceased	024	03	Death
	DE	Duplicate Client Record	024	07	Termination Of Benefits
	DR	Duplicate Enrlmnt in same MCO	024	07	Termination Of Benefits
	DX	SSI/SDX	024	14	Voluntary Withdrawal
	EF	External File - Plan Initiated	024	14	Voluntary Withdrawal
	FH	Fair Hearing	024	14	Voluntary Withdrawal
	IP	Internal Process/Audit	024	14	Voluntary Withdrawal
	IS	Incarceration/ Suspension	024	18	Suspended

Transaction Type	Transaction Reason Code	Transaction Reason Code Description	Maintenance Type Code	Maintenance Reason Code	Maintenance Reason Description
	IT	Internal Transfer	024	XT	Transfer
	JR	JRA/VPS/URM	024	14	Voluntary Withdrawal
	L1	Enrollment Reconnect	024	22	Plan Change
	MD	Newborn - Mom in diff. plan	024	22	Plan Change
	MF	Retro NB enrollment> 21 days or Mom not in MC	024	07	Termination Of Benefits
	MM	BHP+ Mismatch	024	07	Termination Of Benefits
	NP	New Program	024	07	Termination Of Benefits
	OC	Plan Ownership Change	024	07	Termination Of Benefits
	OE	Open Enrollment	024	14	Voluntary Withdrawal
	PC	Program Change	024	07	Termination Of Benefits
	PD	TPL - Dual Coverage	024	14	Voluntary Withdrawal
	PE	Pending Decision	024	14	Voluntary Withdrawal
	PI	TPL	024	14	Voluntary Withdrawal
	PM	Program Manager	024	14	Voluntary Withdrawal
	PT	Plan Termination	024	14	Voluntary Withdrawal
	QQ	Contract Change	024	22	Plan Change

Transaction Type	Transaction Reason Code	Transaction Reason Code Description	Maintenance Type Code	Maintenance Reason Code	Maintenance Reason Description
	RE	RAC Excluded	024	07	Termination Of Benefits
	RM	Medicare Part A/B/C	024	14	Voluntary Withdrawal
	SA	Service Area Change	024	14	Voluntary Withdrawal
	T5	CSHCN	024	14	Voluntary Withdrawal
	TA	TBQ Assignment	024	XT	Transfer
	TT	Program Type Transfer	024	14	Voluntary Withdrawal
	VC	Voluntary County	024	14	Voluntary Withdrawal
	XL	Plan not available	024	XT	Transfer
	XP	Program not available	024	XT	Transfer
	ZZ	Warrant Cancellation	024	07	Termination Of Benefits
Change Transaction	AC	Assignment Confirmed	001	28	Initial Enrollment
	CO	CMCM Offered	001	AI	No Reason Given
	HI	Additional Info	001	33	Personnel Data
	IM	Institution of Mental Diseased	001	AI	No Reason Given
	OO	Opt Out of CMCM	001	AI	No Reason Given
	RA	Responsibility Adjustment Change	001	AI	No Reason Given
	XX	Demographic Change	001	25	Data Elements Change

Transaction Type	Transaction Reason Code	Transaction Reason Code Description	Maintenance Type Code	Maintenance Reason Code	Maintenance Reason Description
	Y1	Client address change	001	43	Change Of Location
	Y2	Rate Change	001	AI	No Reason Given
	Y3	Rate Adjustment	001	AI	No Reason Given
	Y4	RAC or Medicare Status Change	001	AI	No Reason Given
	Y5	Other Address Changes	001	AI	No Reason Given
	Y6	End Date Adjusted	001	AI	No Reason Given
	Z1	Other client change	001	33	Personnel Data
	Z2	Rate affecting dmgrphc change	001	AI	No Reason Given