

# **California Department of Health Care Services**

## **5010 834 Transaction**

## **Benefit Enrollment and Maintenance**

### **Standard Companion Guide Transaction Information**

**Instructions related to Transactions  
Based on ASC X12 Implementation Guides,  
version 005010**

**Companion Guide Version Number: 3.3**

**May 2020**

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## Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Associated TR3s are available at <http://store.x12.org/store>.

## Table of Contents

<b>1</b>	<b>TI Introduction</b>	<b>6</b>
1.1	Background	6
1.1.1	Overview of HIPAA Legislation	6
1.1.2	Compliance according to HIPAA	6
1.1.3	Compliance according to ASC X12	7
1.2	Intended Use	7
<b>2</b>	<b>Included ASC X12 Implementation Guides</b>	<b>7</b>
<b>3</b>	<b>Instruction Tables</b>	<b>7</b>
3.1	Plan Specific Elections	8
3.2	Transaction Availability	8
3.3	Transaction Components	9
3.4	Enrollment File Naming Conventions	9
3.5	834 Data Elements	10
3.6	CBAS Indicator Values	28
3.7	CCI Duals Indicator Values	29
3.8	Additional Indicators	31
3.8.1	Subplan Descriptions	31
3.8.2	CCS / GHPP Indicator	32
<b>4</b>	<b>TI Additional Information</b>	<b>32</b>
4.1	Business Rules and Limitations	32
4.1.1	Notification when no daily 5010 834	32
4.1.2	Data in the 5010 834 Transactions versus in the FAME files	33
4.1.3	Fields in the 5010 834 Transaction data elements versus FAME data	33
4.1.4	Accuracy of Address Data	34
4.2	Frequently Asked Questions	34
4.2.1	What is the File Grouping, and how is it used?	34
4.2.2	Isn't the date in the file name the file creation date?	35

4.2.3	What causes discrepancies between the daily updates and the monthly replacement files? .....	35
4.2.4	Why is the Header DTP File Effective Date segment missing? .....	36
4.2.5	Why is '001' the only code used? .....	36
4.2.6	Why isn't the current Part D status reported here, too?.....	36
4.2.7	How is the Medi-Cal status determined? .....	36
4.2.8	Why would multiple records be reported for the same person? .....	37
4.2.9	Where is the Case Number? .....	37
4.2.10	Why are the Alien Codes missing? .....	37
4.2.11	Why would both COHS and Non-COHS data be reported for a member? .....	37
4.2.12	Why aren't member eligibility dates reported here?.....	37
4.2.13	Why are some months of a member's coverage history missing? .....	38
4.2.14	Does the code '021' mean an Active Enrollment HCP status? .....	38
4.2.15	What happens with disenrollment's and holds?.....	38
4.3	Other Resources – Glossary .....	39
4.3.1	Payer .....	39
4.3.2	Member.....	39
4.3.3	Service Month .....	40
4.3.4	Current.....	40
<b>5</b>	<b>TI Change Summary .....</b>	<b>40</b>

# Transaction Instruction (TI)

## 1 TI Introduction

### 1.1 Background

#### 1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

#### 1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked 'not used' in the standard's implementation specifications or are not in the standard's implementation specification(s).
- Change the meaning or intent of the standard's

implementation specification(s)

### 1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

### 1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide.

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 Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

## 2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X220A	Benefit Enrollment and Maintenance (834)

## 3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Only those elements that require specific explanation are included in these tables. The underlying TR3 document for this transaction is available at <http://store.x12.org>.

The structure of this 834 transaction was implemented from two different

perspectives: Foremost was the compliance of this transaction with HIPAA standards. Secondly, DHCS wanted to provide as much information as possible from our previous proprietary enrollment data feeds to allow trading partners to continue their existing business practices. In the following tables, a number of references are made to our central enrollment database, MEDS, and the previous proprietary extract, FAME.

### **3.1 Plan-Specific Elections**

Plans may elect to receive their enrollment data separated by specific HCP code or have all data grouped on one file (grouped at the vendor level).

Medi-Cal member data sometimes is not compliant with HIPAA requirements with regards to address data. In some cases, the Medi-Cal database MEDS has no record of a zip code or state abbreviations for some members; this is particularly prevalent with homeless or indigent members whose address on file may be quite incomplete.

Since Managed Care Plans may have different requirements with regards to the compliancy of address data, DHCS offers a choice in how the address data is included on the 834. The DHCS default is that only addresses that we know to be compliant shall be sent; however, at the request of a plan, DHCS will suppress our HIPAA-compliance edits on the address segments and send all address data “as-is” that we have on file.

### **3.2 Transaction Availability**

Enrollment data will be uploaded to a plan’s designated Secure File Transfer Protocol (SFTP) “submission” folder administered by DHCS Enterprise Innovation Technology Services (EITS).

Each 834 file will be compressed as a ZIP file archive prior to being uploaded.

The file is created on two separate schedules. A monthly roster file will be created per the published schedule from Medi-Cal Managed Care Operating Division via an All Plan Letter (APL). This monthly file will include all members that are or

have been assigned to a specific plan. As discussed above, a managed care plan (MCP) may receive data for all of the health plan codes (HCP's) that it oversees (grouped at the vendor level), or an MCP may receive data in specific files each dedicated to a specific HCP. Members are included on the 834 for a specific HCP if they are or have been enrolled in that HCP, enrollment history for other HCP's will not be included due to privacy issues.

Example: MyHealth Plan consists of three HCP's – 950, 951 and 952. MyHealth Plan elects to receive their data grouped at the vendor level. The result is an 834 that includes all members who are or have been enrolled in any of their three HCP's (950, 951 or 952).

The daily 834 is created on the evening (or overnight hours) of each state work-day, and consists of members whose MEDS database record have been modified in some manner since the last extract. Member records are organized by HCP or at the vendor level in the same way as the monthly data.

For coordination of care purposes, the current and first previous months enrollment (HCP and status) is included regardless of whether the MCP "owns" the HCP's identified (see Loop 2000 REF\*ZZ).

### **3.3 Transaction Components**

Data element separator will be "\*".

Segment terminator will be "~".

### **3.4 Enrollment File Naming Conventions**

Enrollment files will use the following naming convention:

**DHCS834-XX-CCYYMMDD-VVVVVVVVV-NNN.dat.ZIP**

Where:

XX denotes whether a file is a daily "DA" or monthly "MO".

CCYYMMDD is the date of the file creation.

VVVVVVVVVV can be either a vendor grouping name created by DHCS in coordination with Vendor or an identifier for a specific health plan code.

NNN is a unique numeric transaction identifier used to differentiate between data files sent on the same day.

Example:

**DHCS834-DA-20130510-MyHealthPlan-001.dat.ZIP**

**DHCS834-MO-20130510-MYH-444-001.dat.ZIP** (444 is the HCP)

When no data is available for a specific HCP or vendor grouping, DHCS will post a file with the following naming convention:

**DHCS834-XX-CCYYMMDD-VVVVVVVVVV-NODATA.txt**

Using the same definitions as above.

### 3.5 834 Data Elements

Loop ID	Reference	Name	Codes	Comments
ISA	ISA	Interchange Control Header	This cell left blank intentionally	This cell left blank intentionally
ISA	ISA05	Interchange ID Qualifier	ZZ	Mutually Defined
ISA	ISA06	Interchange Sender ID	CADHCS_5010_834	California Department of Health Care Services
ISA	ISA07	Interchange ID Qualifier	30	U.S. Federal Tax Identification Number (FTIN)
ISA	ISA08	Interchange Receiver ID	<Receiver Code>	The Receiver's FTIN
ISA	ISA11	Repetition	^	New delimiter, replacing

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES 5010 834 COMPANION GUIDE

Loop ID	Reference	Name	Codes	Comments
		Separator		the 4010 data element, Interchange Control
ISA	ISA13	Interchange Control Number	This cell left blank intentionally	Unique 9-digit number, incremented non-sequentially from each previous 834 Transaction sent to Receiver. Example: "000125001". Must be same value as in IEA02.
ISA	ISA15	Interchange Usage Indicator	P T	Each transaction will contain either 'P' (Production Data) or 'T' (Test Data).
ISA	ISA16	Component Element Separator	:	This cell left blank intentionally
GS	GS	Functional Group Header	This cell left blank intentionally	This cell left blank intentionally
GS	GS02	Application Sender's Code	CADHCS_5010_834	The same value as in ISA06
GS	GS03	Application Receiver's Code	<Receiver Code>	The same FTIN as in ISA08
GS	GS06	Group Control Number	1	Unique number between 4 and 9 digits, incremented non-sequentially from each previous 834 Transaction sent to Receiver. Same value as in ISA13/IEA02, except no leading zeros. Example: "125001". Must be same value as in GE02.

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES 5010 834 COMPANION GUIDE

Loop ID	Reference	Name	Codes	Comments
GS	GS08	Version / Release / Industry Identifier Code	005010X220A1	This cell left blank intentionally
GS	ST02	Transaction Set Control Number	0001	There will always be only one Transaction Set per Interchange.
GS	ST03	Implementation Convention Reference	005010X220A1	This cell left blank intentionally
GS	BGN01	Transaction Set Purpose Code	00 15	'00' (Original) indicates the first time the transaction is sent. '15' (Re-Submission) indicates another transmission of a transaction.
GS	BGN02	Reference Identification	This cell left blank intentionally	The daily or monthly file name. Please read the FAQs – 4.2.1 “What is the File Grouping, and how is it used?” 4.2.2 “Isn’t the date in the file name the file creation date?”
GS	BGN06	Reference Identification	This cell left blank intentionally	If BGN01 = '15' this field will contain the transaction identifier (BGN02) of the transaction set being replaced.
GS	BGN08	Action Code	2 RX	'2' (Change, Update) will be used for daily files. 'RX' (Replace) will be used for monthly files. Please read the FAQ 4.2.3 “What causes discrepancies between

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES 5010 834 COMPANION GUIDE

Loop ID	Reference	Name	Codes	Comments
				the daily updates and the monthly replacement files?"
GS	N101	Entity Identifier Code	P5	Plan Sponsor
GS	N102	Name	"California Department of Health Care Services..... ..."	The number of periods may vary.
GS	N103	Identification Code Qualifier	FI	Federal Taxpayer's Identification Number
GS	N104	Identification Code	680317191	This cell left blank intentionally
GS	N102	Name	This cell left blank intentionally	The same Vendor Group or Vendor name as used on the 5010 820 transaction.
GS	N103	Identification Code Qualifier	FI	Federal Taxpayer's Identification Number
GS	N104	Identification Code	This cell left blank intentionally	The same Vendor FTIN as in ISA08.
GS	INS01	Yes/No Condition or Response Code	Y	All Medi-Cal members are subscribers, so this Subscriber Indicator is always 'Y' (Yes).
GS	INS02	Individual Relationship Code	18	Self
GS	INS03	Maintenance Type Code	001	Please read the FAQ 4.2.5 "Why is '001' the only code used?"
GS	INS04	Maintenance Reason Code	AI	'AI' (Reason Not Given) is the only correct code because the actual

Loop ID	Reference	Name	Codes	Comments
				cause for the record's inclusion in the transaction cannot be determined.
GS	INS05	Benefit Status Code	A	'A' (Active) is the only applicable code provided to describe Medi-Cal status.
GS	INS06	Medicare Status Code	A B C E	Changes in the member's Medicare Status for Parts A, B and D are reported over time in 2300-REF-REF02 when REF01 = 9V. The value reported here is based on the current value of these Medicare Codes for Parts A and B only. Please read the FAQ 4.2.6 "Why isn't the current Part D status reported here, too?"
GS	INS08	Employment Status Code	AC TE	'AC' (Active) and 'TE' (Terminated) are the only allowed options for Medicaid. Please read the FAQ 4.2.7 "How is the Medi-Cal status determined?"
GS	INS12	Date Time Period	<CCYYMMDD>	Member's Death Date
2000	REF	Subscriber Identifier	This cell left blank intentionally	Based on the source FAME data, a separate member record (i.e., a separate 2000 Loop) is created for each MEDS ID. Please read the FAQ 4.2.8 "Why would multiple

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES 5010 834 COMPANION GUIDE

Loop ID	Reference	Name	Codes	Comments
				records be reported for the same person?" This element is not part of the X12N implementation guide.
2000	REF01	Reference Identification Qualifier	0F	Subscriber Number
2000	REF02	Reference Identification	This cell left blank intentionally	CIN, Client Index Number, is the member's primary identifier in this transaction.
2000	REF	Member Policy Number	This cell left blank intentionally	This cell left blank intentionally
2000	REF01	Reference Identification Qualifier	1L	Member Group or Policy Number
2000	REF02	Reference Identification	This cell left blank intentionally	MEDS-ID
2000	REF	Member Supplemental Identifier	This cell left blank intentionally	Other FAME data required by the Payer and related to the subscriber's Medi-Cal record for the current month is reported in this segment. Although some qualify, rather than identify, this is the most appropriate location for this data. This element is not part of the X12N implementation guide.
2000	REF01	Reference Identification Qualifier	17 23 3H 6O DX F6 Q4	The following qualifiers are used to reference the FAME data indicated in REF02: '17' Client Reporting Category '23' Client Number '3H' Case Number

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES 5010 834 COMPANION GUIDE

Loop ID	Reference	Name	Codes	Comments
			QQ ABB ZZ	'6O' Cross Reference Number 'F6' Medicare Beneficiary Identifier (MBI) (11 Characters in length, Excluding letters –S,L,O,I,B and Z) 'Q4' Prior Identifier Number 'QQ' Unit Number 'DX' Department/Agency Number Reserved: 'ABB' Personal ID Number 'ZZ' Mutually Defined
2000	REF02	Reference Identification	This cell left blank intentionally	'17' = Redetermination Date;Death Date Posted; MEDS Renewal Date; Expected Delivery Date '23' = CIN Check Digit <b>(for COHS only)</b> ;Card Issue Date;Paper Card Date '3H' = County Code;Aid Code;Case Number;Case Name;County District Code (Note: The County ID is parsed out into its 3 sub- components of County Code, Aid Code, and Case Number). '6O' = CCS/GHPP Indicator;Residence Address Flag;Residence Address Indicator; Mailing Address Flag;

Loop ID	Reference	Name	Codes	Comments
				<p>Residence Zip Delivery Code;Mailing Zip Delivery Code                      'F6' = MBI                      'Q4' = Prior MEDS ID;Chained MEDS ID                      'QQ' = <b>(for COHS only)</b>                      Term Reason;Term Date                      'DX' = <b>(for Non-COHS only)</b> Federal Contract Number;State Carrier Code;Policy Start Date                      'ZZ" = HCP and HCP Status for the member's active enrollments, (up to five plans reported for each of the current month and the first prior month, to promote coordination of care – data separated by semi-colon) If the codes in REF01 correspond to multiple FAME data elements in REF02, the values for each data element will be concatenated in the defined order, and delimited with a semi-colon “;”.</p> <p>Please read the FAQs – 4.2.9 “Where is the Case Number?” 4.2.10 “Why are the Alien Codes missing?” and 4.2.11 “Why would both COHS</p>

Loop ID	Reference	Name	Codes	Comments
				and Non-COHS data be reported for a member?"
2100A	NM1	Member Name	This cell left blank intentionally	With the exception of certain descriptors reported in 2000-REF-REF02 when 2000-REF-REF01=6O, all the member's personal and contact information is reported in this 2100A Loop.
2100A	NM101	Entity Identifier Code	IL	Insured or Subscriber
2100A	PER	Member Communication Numbers	This cell left blank intentionally	This cell left blank intentionally
2100A	PER03	Communication Number Qualifier	TE	Telephone
2100A	PER04	Communication Number	This cell left blank intentionally	Beneficiary Phone number
2100A	N3	Member Residence Street Address	This cell left blank intentionally	For Plans (Vendor Groups) who choose to receive all address data, segments N3 and N4 in Loop 2100A will be populated with the Residence Address information regardless of the FAME-RES-ADDR-FLAG value. For Plans (Vendor Groups) who choose to receive address data according to the Address Flag: If FAME RES-

Loop ID	Reference	Name	Codes	Comments
				ADDR-FLAG does NOT equal "A" or "W", then segments N3 and N4 in Loop 2100A will be omitted. This element is not part of the X12N implementation guide.
2100A	N4	Member City, State, ZIP Code	This cell left blank intentionally	For Plans (Vendor Groups) who choose to receive all address data, segments N3 and N4 in Loop 2100A will be populated with the Residence Address information regardless of the FAME-RES-ADDR-FLAG value. For Plans (Vendor Groups) who choose to receive address data based on the Address Flag: If FAME RES-ADDR-FLAG does NOT equal "A" or "W", then segments N3 and N4 in Loop 2100A will be omitted. This element is not part of the X12N implementation guide.
2100A	N401	City Name	This cell left blank intentionally	FAME Residence City, State
2100A	N402	State or Province Code	This cell left blank intentionally	FAME Residence State
2100A	N403	Postal Code	This cell left blank intentionally	FAME Residence Zip code and Zip plus 4 code
2100A	N405	Location Qualifier	CY	County
2100A	N406	Location	This cell left blank	County of Residence

Loop ID	Reference	Name	Codes	Comments
		Identifier	intentionally	
2100A	DMG	Member Demographics	This cell left blank intentionally	This cell left blank intentionally
2100A	DMG05	Composite Race or Ethnicity Information	This cell left blank intentionally	All but three FAME Ethnic codes map to an industry code in DMG05-3; these are reported in DMG05-1.
2100A	DMG05-1	Race or Ethnicity Code	7 F	'7' = FAME Ethnic codes '8' (No Valid Data Reported. Generated by MEDS) and '9' (No response, client declined to state), as well as blank or NULL values 'F' = the FAME Ethnic code 'A' (Amerasian)
2100A	DMG05-3	Industry Code	2106-3 2135-2 2054-5 2028-9 1002-5 2036-2 2034-7 2033-9 2039-6 2040-4 2080-0 2029-7 2076-8 2087-5 2041-2 2047-9 2131-1	If DMG05-2 is populated, the RET codes correspond as follows to the FAME Ethnic codes '2106-3' = 1 – White '2135-2' = 2 – Hispanic '2054-5' = 3 – Black '2028-9' = 4 – Asian or Pacific Islander '1002-5' = 5 – Alaskan Native or American Indian '2036-2' = 7 – Filipino '2034-7' = C – Chinese '2033-9' = H – Cambodian '2039-6' = J – Japanese '2040-4' = K – Korean

Loop ID	Reference	Name	Codes	Comments
				'2080-0' = M – Samoan '2029-7' = N – Asian Indian '2076-8' = P – Hawaiian '2087-5' = R – Guamanian '2041-2' = T – Laotian '2047-9' = V – Vietnamese '2131-1' = Z – Other
2100A	LUI	Member Language	This cell left blank intentionally	If a member is on record as speaking English, this segment is not populated. This element is not part of the X12N implementation guide.
2100A	LUI01	Identification Code Qualifier	LD	If LUI03 is populated, this field will be blank. Otherwise, 'LD' indicates NISO Z39.53 Language Codes and describes the codes used in LUI02.
2100A	LUI02	Identification Code	SPA JPN KOR TGL CHI ARM LAO TUR HEB FRE POL RUS POR	If LUI01 is populated, the NISO Z39.53 Language codes correspond as follows to the FAME Language codes: 'SPA' = 1 – Spanish 'JPN' = 3 – Japanese 'KOR' = 4 – Korean 'TGL' = 5 – Tagalog 'CHI' = C – Other Chinese Languages 'ARM' = E – Armenian 'LAO' = I – Lao 'TUR' = J – Turkish

Loop ID	Reference	Name	Codes	Comments
			ITA ARA SMO THA VIE UND	'HEB' = K – Hebrew 'FRE' = L – French 'POL' = M – Polish 'RUS' = N – Russian 'POR' = P – Portuguese 'ITA' = Q – Italian 'ARA' = R – Arabic 'SMO' = S – Samoan 'THA' = T – Thai 'VIE' = V – Vietnamese 'UND' (Undetermined) = NULL or blank field
2100A	LUI03	This cell left blank intentionally	0 2 6 A B D F G H U 8 9	The FAME language codes that do not correspond to any LD codes are reported here, as follows: '0' – American Sign Language '2' – Cantonese '6' – Other Non-English 'A' – Other Sign Language 'B' – Mandarin 'D' – Cambodian 'F' – Ilocano 'G' – Mien 'H' – Hmong 'U' – Farsi '8' – No Valid Data Reported (MEDS generated) '9' – No response, client declined to state If any other value is found in the source data, it will be reported here.



Loop ID	Reference	Name	Codes	Comments
		Coverage	intentionally	member's current and historic monthly data regarding eligibility, enrollment and benefits in the Payer's Health Care Plan(s), as constrained by the limitations described in the FAQs for BGN08. No 2300 Loop is created for any period in which the HCP Status is blank in the source data. Please read the FAQ 4.2.13 "Why are some months of a member's coverage history missing?" This element is not part of the X12N implementation guide.
2300	HD01	Maintenance Type Code	001 021	Please read the FAQs – 4.2.14 "Does the code '021' mean an Active enrollment HCP status?" and 4.2.15 "What happens with disenrollments and holds?"
2300	HD03	Insurance Line Code	DEN HLT LTC	This field is populated based on the HCP number. HCP numbers in the range of 400-499 are Dental Plans.
2300	HD04	Plan Coverage Description	This cell left blank intentionally	The HCP number and HCP status
2300	DTP	Health Coverage Dates	This cell left blank intentionally	Although health coverage is reported in service months spanning from a Benefit Begin date to a Benefit End date, these dates are reported

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES 5010 834 COMPANION GUIDE

Loop ID	Reference	Name	Codes	Comments
				separately due to the 5010 834 IG constraint placed on the use of a date range. This element is not part of the X12N implementation guide.
2300	DTP01	Date/Time Qualifier	348 349	'348' (Benefit Begin) describes the start date of the service month being reported. '349' (Benefit End) describes either the end date of the same service month, or – in the case of a termination or other period of no coverage – the end date of the prior month.
2300	AMT	Health Coverage Policy	This cell left blank intentionally	This cell left blank intentionally
2300	AMT01	Amount Qualifier Code	R	Spend Down. The remaining Share of Cost for the corresponding service month.
2300	AMT02	Monetary Amount	This cell left blank intentionally	The member's Share of Cost Amount
2300	REF	Health Coverage Policy Number	This cell left blank intentionally	Other FAME data related to the subscriber's health coverage record, and essential to the Payer, are reported in this segment. This element is not part of the X12N implementation guide.
2300	REF01	Reference Identification	17 9V	The following qualifiers are used to reference the

Loop ID	Reference	Name	Codes	Comments
		Qualifier	CE E8 RB XX1 ZX ZZ	FAME data indicated in REF02: ‘17’ – Client Reporting Category ‘9V’ – Payment Category ‘CE’ – Class of Contract Code ‘E8’ – Service Contract Number ‘RB’ – Rate Code Number ‘XX1’ – Special Program Code ‘ZX’ – County Code ‘ZZ’ – Mutually Defined
2300	REF02	Reference Identification	This cell left blank intentionally	‘17’ = (The following or blanks separated by semi-colons): OHC; CBAS-IND 1 <sup>st</sup> digit ; CBAS-IND 2 <sup>nd</sup> digit; CCI Opt Out Indicator; ESRD Indicator; Part D LIS Reassigned Indicator; CCI Exclusion Indicator; Nursing Facility Resident; SI-NSI indicator; HCBS HIGH indicator; INSTITUTIONAL indicator; SUBPLAN indicator; ‘9V’ = (The following or blanks separated by semi-colons): Medicare Part A Status Code; Medicare Part B Status

Loop ID	Reference	Name	Codes	Comments
				Code; Medicare Part D Status Code 'CE' = All the Aid Codes and Eligibility Status Codes separated by blanks or semi-colons: Primary AID-CODE; ESC; SPEC1- AID; SPEC1-ESC; SPEC2- AID; SPEC2-ESC; SPEC- AID; SPEC3-ESC 'E8' = the following <b><u>COHS-Only</u></b> data elements or blanks separated by semi-colons: Multiple SOC case indicator; Percent obligation 'RB' = Capitated aid code 'XX1' = Restricted service code 'ZX' = County code, from the monthly section of FAME data. 'ZZ' = The Following elements or blanks separated by semi-colons: Healthy Families In and Out days; SOC certification day; Segment ID;
GE	GE	Functional Group Trailer	This cell left blank intentionally	This cell left blank intentionally
GE	GE01	Number of	1	There will always be only

Loop ID	Reference	Name	Codes	Comments
		Transaction Sets Included		one Transaction Set within the Functional Group segment.
GE	GE02	Group Control Number	1	Unique number between 4 and 9 digits, incremented non-sequentially from each previous 834 Transaction sent to Receiver. Same value as in ISA13/IEA02, except no leading zeros. Example: "125001". Must be same value as in GS06.
IEA	IEA	Interchange Control Trailer	This cell left blank intentionally	This cell left blank intentionally
IEA	IEA01	Number of Included Functional Groups	1	There will always be only one Functional Group within the Interchange Control segment.
IEA	IEA02	Interchange Control Number	This cell left blank intentionally	Unique 9 digit number, incremented non-sequentially from each previous 834 Transaction sent to Receiver. Example: "000125001". Must be same value as in ISA13.

### 3.6 CBAS Indicator Values

#### **First Digit – CBAS Indicator Class:**

Valid values are "1", "2", "3", "4", "5" or "9" where:

- 1 = CBAS Enrollment – Class 1 7/1/11 – 2/29/12 (eligible for ECM)
- 2 = ECM Enrollment – Class 1 7/1/11 – 2/29/12 (not eligible for CBAS)
- 3 = CBAS Enrollment – Class 2 3/1/12 – 8/30/2014 (never eligible for ECM)
- 4 = Unbundled – Class 1
- 5 = Unbundled – Class 2
- 9 = No longer enrolled in CBAS or ECM

**Second Digit – Medi-Cal Indicator Participation:**

- A = Full Dual in Managed Care
- B = Full Dual in Fee-for-Service
- C = Partial Dual in Managed Care
- D = Partial Dual in Fee-For-Service
- E = SPD in Managed Care
- F = SPD in fee-For Service
- G = Managed Care (Not Dual or SPD)
- H = Fee-For-Service (Not Dual or SPD)

**3.7 CCI Duals Indicator Values**

All indicators for CCI Duals and MLTSS included in this section are one character in length.

**CCI Opt out indicator:**

- “Y” – Beneficiary opted out of Cal Medi-Connect and will not be included in future passive enrollments.

- Null – Beneficiary has not opted out of Cal Medi-Connect

**ESRD (End Stage Renal Disease) indicator:**

- “Y” – Beneficiary has a diagnosis of ESRD within the specified timeframe and is excluded from a Cal Medi-Connect (800-series) HCP, except in San Mateo and Orange counties, but is included in MLTSS.
- “N” – Beneficiary has a diagnosis of ESRD outside the specified timeframe and is not excluded from Cal Medi-Connect.
- Null – Beneficiary has no diagnosis of ESRD.

**Part D LIS Reassigned indicator:**

- “Y” – Beneficiary is LIS reassigned and excluded from passive enrollment until 1/1/2015.
- Null – Beneficiary is not Part D LIS reassigned

**CCI Exclusion Indicator:**

“M” – Beneficiary is in a Multipurpose Senior Services Program (MSSP), and is eligible for enrollment in Cal Medi-Connect and MLTSS.

“N” – Beneficiary is in MSSP and is a Veterans' Home resident - Not eligible for a Cal Medi-Connect or MLTSS enrollment.

“O” – Beneficiary is in a 1915 (c) waiver - Not eligible for a Cal Medi-Connect enrollment, but is eligible for MLTSS.

“P” – Beneficiary is in a 1915 (c) waiver and a Veterans' Home resident -Not eligible for a Cal Medi-Connect or MLTSS enrollment.

“V” - Beneficiary is a Veterans' Home resident - Not eligible for Cal Medi-Connect or MLTSS enrollment.

“D” – Beneficiary is in a Developmentally Disabled waiver - Not available for Cal Medi-Connect enrollment, but is eligible for MLTSS.

“I” – Beneficiary is in an ICF DD and not available for a Cal Medi-Connect or MLTSS enrollment.

Null – no data available.

**Nursing Facility Resident:**

- “Y” – Beneficiary is a resident of a nursing facility
- Null – No information exists that indicates whether the beneficiary is a resident of a nursing facility or not.
- Please note that the daily 834 files will receive daily indicators, and the monthly indicators will not display the history, only current month will populate.

**3.8 Additional Indicators**

Field	Format	Length	Valid Values	Description
SI-NSI Indicator	Alpha-Numeric	1	S=SI N=NSI <blank>	Identifies IHSS beneficiary as Severely Impaired – Non Severely Impaired
HCBS HIGH INDICATOR	Alpha-Numeric	1	Y = Yes N = No <blank>	If “Y”, Plan is reporting to DHCS that beneficiary is receiving CBAS and/or MSSP services
INSTITUTIONAL INDICATOR	Alpha-Numeric	1	Y = Yes N = No <blank>	If “Y”, beneficiary has been identified as being in a Long-term care facility
SUBPLAN INDICATOR	Alpha-Numeric	2	See list below	Identifies beneficiaries enrolled in a subcontracted health plan

**3.8.1 Subplan Descriptions**

Subplan	Description	MEDS Subplan Indicators
BC	Anthem Blue Cross Partnrshp	B
CF	Care1st Partner Plan, LLC	F
CH	Community Health Plan	C
HN	Health Net Comm Solutions	H
KA	KP Cal, LLC	K
LA	L.A. Care Health Plan	L
MO	Molina Healthcare Partner	M
<blank>	No Subplan	<BLANK>

**3.8.2 CCS / GHPP Indicator:**

Name: CCS / GHPP Indicator

Length: Single byte (may be blank)

Type: Alpha-numeric

Values:

“1” – CCS in last 6 months

“2” – GHPP in last 6 months

“3” – Both in last 6 months

“Blank” – Neither in last 6 months / no information available

## 4 TI Additional Information

This section contains background information, frequently asked questions, and business scenarios that describe and illustrate the business context that confines the DHCS 5010 834 transaction.

### 4.1 Business Rules and Limitations

This section contains background information on the business rules, processes, and data limitations that impact how the DHCS 834 transaction can be used.

#### 4.1.1 Notification when no daily 5010 834 Transaction has been created.

When there are no member changes to be reported to a Vendor, a daily 5010 834 Transaction will not be created, and a text file named <DHCS834- DA-CCYYMMDD-VENDORGROUPNAME-NODATA.txt> will be automatically placed in the Vendor’s SFTP folder.

#### **4.1.2 Data in the 5010 834 Transactions versus in the FAME files.**

The data content will remain the same. The process of extracting data from MEDS to create the source FAME files will remain unchanged, and the FAME data will not be changed in the process of creating the 5010 834 Transactions. Consequently, although the layout is different, the 5010 834 reporting of aid codes, eligibility codes, HCP codes, and any other extracted data will remain the same, and the way these values change in different business scenarios will also remain the same. Ethnic codes, language codes, and a few other codes specific to the 5010 834 Transaction are derived from the extracted FAME data, consult existing MEDS documentation for field descriptions.

Most significantly, the 5010 834 Transaction will not always report the member's entire record, as found in the source FAME file. The reasons are explained in the FAQs 4.2.3 "What causes discrepancies between the daily updates and the monthly replacement files?" and 4.2.13 "Why are some months of a member's coverage history missing?"

#### **4.1.3 Fields in the 5010 834 Transaction data elements versus FAME data.**

A fundamental conflict exists between the structure of the 834 Transaction and the nature of the source data available for populating the DHCS 5010 834 Transaction. The 834 Transaction is designed to report individual, dated events, with the intention that the data would accumulate over time to give a chronological history of a member's health coverage. By contrast, the DHCS source data that resides in the legacy MEDS system is overwritten by daily feeds from an array of outside sources. The entire system is also 'renewed' monthly, when programming logic is applied and eligibility records are rolled forward one month. Consequently, DHCS is able to provide valid 'snapshots' of members' eligibility and enrollment status, but not the kind of change data intended on the 5010 834 Transaction.

Furthermore, the 5010 834 Transaction does not provide designated data elements for some of the detailed FAME data elements that Plans have been relying on for years. In order to continue providing this information, multiple FAME fields have been mapped to certain 834 data elements, and delimited with a semi-colon “;”.

#### **4.1.4 Accuracy of Address Data.**

The source data for the 834 transaction is the DHCS MEDS database that receives updates from many sources most notably from County welfare offices. In many cases, address data for Medi-Cal beneficiaries is incomplete and inaccurate. DHCS attempts to correct as much address data as possible by regularly sweeping the data with appropriate address validation software, however, this still results in many addresses being invalid by HIPAA standards.

During trading partner system testing the issue of non-compliant address data was raised by a number of plans. Most plans requested to receive address “as-is” to support their existing business practices. In order to provide managed care plans with the greatest flexibility, DHCS requested each managed care plan to select whether they wish to receive only compliant addresses or whether they wish to receive all address information regardless of its perceived accuracy. DHCS then instituted a systematic function point within the 834 creation process that takes a plan’s choice into account while the 834 is processed. If a plan has selected to receive only compliant address data, and a member’s address is found that fails this specification, the relevant address segments in loops 2100A or 2100C are omitted

## **4.2 Frequently Asked Questions**

This section contains questions and answers related to specific segments and data elements referenced in the Instruction Table of Section 3.

### **4.2.1 What is the File Grouping, and how is it used?**

Header BGN02: The File Grouping, used in the naming of the DHCS 5010 834 Transaction files, is based on the Vendor Grouping reference table used by the DHCS 5010 834 System to determine which HCP member data to populate on each Vendor's 834 Transaction, and which corresponding Vendor Name and Federal Tax Identification Number will populate the 834 Control Headers and the Payer Loop. The grouping of member data within the 834 Transactions has been specified by each Vendor. Vendors with multiple HCPs can either choose to receive all the member data they handle in a single 834 Transaction (Vendor based), or to receive individual 834 Transactions for each of their HCPs (HCP based).

#### **4.2.2 Isn't the date in the file name the file creation date?**

Header BGN02: The date in the file name refers to the last-modified date on the MEDs data that was extracted. This date can be viewed as an "as-of" date. The file name is populated in BGN02. The 'file creation date' refers to the date processing is completed, and can be a day after the file 'as of date', particularly for the monthly replacement files. In the event of production delays, multiple 834 files could have the same file creation date. The file creation date is reported in ISA09, GS04, and BGN03.

#### **4.2.3 What causes discrepancies between the daily updates and the monthly replacement files?**

Header BGN08: Due to current limitations in the extraction processes that create the FAME source data, the scope of member data reported differs between the daily update file and the monthly replacement file. The daily update file contains a member's record if any change has been made to the member's full MEDS record – even if the changed data is not included among the fields reported on the Payer's daily 834 update file. For Non- COHS plans, the Payer's monthly 834 replacement file will not contain a member's record unless there has

been involvement in the Payer's Plan(s) during the current month, or either of the two prior months. Consequently, a member's record can be included on a daily 834 update file even if it is identical to the record in the Payer's system. Furthermore, if the member's record does show retroactive changes on the daily update, this same member's record may be missing from the following monthly replacement file if the member has been out of the Payer's plan for the current and two most recent prior months. For COHS plans, monthly files contain all records with activity in the last 15 months.

#### **4.2.4 Why is the Header DTP File Effective Date segment missing?**

Header DTP, File Effective Date: This segment is not used because the data in the file is immediately effective upon upload to the receiver's system, and there are no business rules or data elements that depend on the effective date. The file name includes a file 'as of date' that indicates the last modified date of the MEDS data that is represented in the file.

#### **4.2.5 Why is '001' the only code used?**

INS03: '001' (Change) has been used for both daily and monthly transactions for two reasons:

- 1) Both the daily update files and the monthly replacement files contain changes.
- 2) The source data does not provide sufficient information to determine usage of the other codes available in the 5010 834 Implementation Guide.

#### **4.2.6 Why isn't the current Part D status reported here, too?**

INS06: The 834 codes allowed do not address Part D status.

#### **4.2.7 How is the Medi-Cal status determined?**

INS08: Since the member may be concurrently reported in more than one Plan, DHCS populates INS08 with an overall Medi-Cal eligibility status, based on the primary and special Eligibility Status

Codes (ESCs) reported for the current month. Although all of the member's specific Medi-Cal Eligibility Status Codes are reported in the 2300 Loop as Health Coverage data, they apply at the member level to all Plans.

**4.2.8 Why would multiple records be reported for the same person?**

2000-REF: The MEDS ID is the primary identifier on the legacy MEDS system, and is used to create the source FAME data. A limited number of members have been assigned more than one MEDS ID (generally having the same CIN however). Since the DHCS 5010 834 Transaction is keyed by CIN, it is possible for a member to be reported multiple times on a file.

**4.2.9 Where is the Case Number?**

2000-REF-REF02: The Case Number is part of the member's concatenated County ID, which is made up of the responsible County Code, the Aid Code, and the Case Number. The Case Number itself is made up of the Serial number, the Family Budget Unit (FBU), and Person Number.

**4.2.10 Why are the Alien Codes missing?**

2000-REF-REF02: These codes are among the data provided by the Social Security Administration to DHCS, on condition that they will not be shared with other entities.

**4.2.11 Why would both COHS and Non-COHS data be reported for a member?**

2000-REF-REF02: If a member has history with both COHS and Non-COHS Plans, certain member level data normally only available to either COHS or Non-COHS model types will be reported here, regardless of the model type of the Payer's Plan(s).

**4.2.12 Why aren't member eligibility dates reported here?**

2000-DTP: This segment is not used because the member's Medi-Cal eligibility Begin Date cannot be reliably inferred from the available

FAME source data. The member may be concurrently reported in more than one Plan, and Plan-specific dates are reported in the 2300 Loop.

**4.2.13 Why are some months of a member’s coverage history missing?**

2300-HD: There are several reasons months of coverage history are not always reported for a member.

- 1) Blank FAME history segments are not included on the 834 Transaction.
- 2) Historic information regarding involvement in Plans managed by other Payers is excluded from this Loop, in conformance with the HIPAA requirement to provide the minimum data necessary. However, to promote coordination of care for members that are actively enrolled in multiple Plans (i.e., between all the member’s Plans with an HCP status of 01, S1, 51, 41, 61, or B1 in the current month or first prior month), the Plan(s) not reported in 2300-HD-HD04, will be listed in 2000-REF-REF02 when REF01 = ‘ZZ’.
- 3) Thirteen service months are reported for Non-COHS Plans and sixteen service months are reported for COHS Plans. A member that switches from a Non-COHS Plan to a COHS Plan may not initially have the additional three months history. Please read the FAQ 4.2.11 “Why would both COHS and Non-COHS data be reported for a member?”

**4.2.14 Does the code ‘021’ mean an Active Enrollment HCP status?**

2300-HD01: Yes, ‘021’ (Addition) indicates a service month of health coverage during which the member is eligible for Plan benefits under an HCP Status of 01, 51, 41, 61, S1, or B1.

**4.2.15 What happens with disenrollments and holds?**

2300-HD01: ‘001’ (Change) indicates any period with no health coverage in the Plan identified in HD04 – that is, a disenrollment (aka an ‘explicit termination’ with an HCP Status of 00, 09, 10, 19, S0, or S9) or other period of no health coverage (with an HCP Status of P4,

05, 59, 40, 49 or 55). Both disenrollment's and other periods of no coverage must be categorized as '001' (Change) due to the limited options provided for describing the related service month, particularly when the change is retroactive. The non-covered service month is represented in 2300-HD-DTP03 with a Benefit End date that immediately precedes the corresponding Benefit Begin date (aka a 'flat termination').

#### **4.2.16 How should members with HCP Status Code of B1 be handled?**

HCP Status Code 'B1' indicates that the beneficiary is a recently born infant, and will be covered under the mother's coverage until the infant has established coverage. 'B1' is considered to be active and eligible for coverage. The 834 transaction logic has been updated to reflect 'B1' as active enrollment (Maintenance Code = 021).

#### **4.2.17 Medicare Beneficiary Identifier (MBI) replacing Health Care**

##### **Insurance number (HICN)?**

The MBI is replacing the HIC Number field (Loop 2000, Ref01, Value 'F6') in the 834 files. The MBI Field is 11 characters in length excluding S, L, O, I, B, Z letters. It should not include any embedded intelligence or special characters.

### **4.3 Other Resources – Glossary**

#### **4.3.1 Payer**

The 5010 834 Transaction refers to the organization that administers benefits as a Payer. In relation to Medi-Cal, the Payer is a Managed Care Plan (MCO). Sometimes a MCO is also a single Health Care Plan, and is simply referred to as a Plan. In relation to DHCS capitation payments, an MCO is also referred to as a Vendor.

#### **4.3.2 Member**

The 5010 834 Transaction refers to an insured individual as a

member. In relation to Medi-Cal, all members are subscribers. Another common term for the member is beneficiary.

**4.3.3 Service Month**

In the DHCS 5010 834 Transaction, each Service Month, or monthly period of health coverage information, is independently identified by its calendar date period, rather than by its FAME Sequence ID relative to the Month of Eligibility (MOE) that is generated during the MEDS Renewal process.

Consequently, certain terms that relate to the FAME layout will lose meaning, such as the MEDS Renewal Date, and references to sequential historic months as ‘1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup> prior month, etc.

**4.3.4 Current**

Managed Care Medi-Cal eligibility is based upon a rolling monthly system. Simply stated, the “current” month refers to the month that is presently in effect. If today is July 16<sup>th</sup>, the current month is July –this is referred to as the Month of Eligibility (MOE). A few days before the end of a month, the MEDS Renewal Process updates MEDS for the next MOE by rolling members’ eligibility forward where appropriate. The result of this process is that in the MEDS system and on its output data, the current month is now prematurely shifted to the next calendar month. For example, on July 25<sup>th</sup> the MEDS MOE is considered to be July, however, once MEDS Renewal runs on July 26<sup>th</sup> the MEDS MOE is considered to be August.

**5 TI Change Summary**

Version	Date	Updates/Comments
1.0	09/29/2011	OHC draft feedback incorporated.
1.1a	12/09/2011	Correction of minor inaccuracies
1.2	01/24/2012	Modifications for fields:

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES 5010 834 COMPANION GUIDE

Version	Date	Updates/Comments
		<ul style="list-style-type: none"> <li>Remove leading zeros in GS06 and GE02. Change value to "1".</li> <li>Remove Trailing spaces in N102. Replace with periods (variable length) – such as "California Department of Health Care Services.."</li> <li>ISA06/ GS02: Change value so that there are no blank spaces. Value will be: "CADHCS-5010- 834"</li> </ul>
1.3	02/23/2012	Modifications for fields: <ul style="list-style-type: none"> <li>Loop 2000, REF02, Qualifier Code 3H, County ID</li> <li>ISA06/GS02</li> <li>Residence and Mailing Address (Flag logic)</li> <li>Update FAQ 4.2.3 for COHS logic</li> <li>Loop 2300, REF*9V – update Medicare status code description</li> </ul>
1.4	03/14/2012	<ul style="list-style-type: none"> <li>Updated logic for Interchange Control Number values used in ISA13 and IEA02.</li> <li>Mapped "MEDS Renewal Date" to Loop 2000, REF02, Qualifier Code 17.</li> <li>Mapped "Segment ID" to Loop 2300, REF02, Qualifier Code ZZ.</li> </ul>
1.5	4/20/2012	Updated Notes/Comments for the following fields: <ul style="list-style-type: none"> <li>ISA13</li> <li>GS06</li> <li>GE02</li> <li>IEA02</li> <li>Loop 2100A, N3 and N4</li> <li>Loop 2100C</li> </ul>
1.6	10/19/2012	Updated CBAS Indicator mapping. <ul style="list-style-type: none"> <li>Loop 2300, REF02</li> </ul>
1.7	01/22/2013	Updated address comments.
1.8	04/25/2013	Submitted for X12 Review.
1.9	06/24/2013	Include Cal Medi-Connect files in 2300 REF*17, update Section 3 information. Include definitions for CBAS and CCI Duals indicators
1.91	07/18/2013	Update Cal Medi-Connect definitions, include daily/monthly schedule narrative. The implementation of these indicators is on-hold.
1.92	09/10/2013	Update Cal Medi-Connect and MLTSS indicators. The implementation of these indicators has not yet been scheduled.
2.0	09/25/2013	Address X12 requirements.
2.1	7/14/2014	Added CCI indicators in Loop 2300 REF 17

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES 5010 834 COMPANION GUIDE

<b>Version</b>	<b>Date</b>	<b>Updates/Comments</b>
2.2	9/23/14	Updated MEDS Subplan Indicators under section 3.8 Additional Indicators
2.3	11/14/14	Updated 3.8 section to add CCS/GHPP Indicator (replaces CMS indicator)
2.4	1/27/15	Updated Section 3.8 Additional Indicators - HCBS HIGH INDICATOR Description; Updated 3.7 CCI Duals Indicator Values
2.5	3/6/15	Updated Sections 3.5 834 Data Elements - Loop 2300, REF01, Reference 17, Notes, Comments; Section 3.8 Additional Indicators by switching the INSTITUTIONAL indicator and HCBS HIGH indicator positions.
2.6	4/13/15	Updated Sections 3.5 834 Data Elements - Loop 2300, REF01, Reference 17, Notes, Comments; Section 3.8 Additional Indicators by switching the HCBS HIGH indicator and INSTITUTIONAL indicator positions back to their original positions on this document. (Coding occurred on the back end to fix the initial issue.)
2.7	5/7/15	Update HCBS High Indicator - from If "Y", Beneficiary is receiving CBAS services to, If "Y", Plan is reporting to DHCS that beneficiary is receiving CBAS and/or MSSP services.
2.8	7/6/15	Updated for ADA compliance (modified tables, formats, and colors), removed old implementation sections 4.1.5 Layout of the 5010 834 versus of the FAME files and 4.3 Business Scenarios.
2.9	11/10/15	Modified Section 3.8 Additional Indicators (page 28) - HCBS High Indicator description that was left off from 2.7v.
3.0	04/18/2016	Modified Section 3.5 Data Elements (page 15) – Added Expected Delivery Date to Loop 2000, REF 17. Expecting 8 characters in the format of CCYYMMDD.
3.1	08/09/2017	Updated FAQ 4.2.13 & 4.2.15 (Page 35) to reflect HCP Status Codes 'B1', '41' and '61' as being acknowledged as active enrollment. Added FAQ 4.2.16 (Page 36) item which explains 'B1' definition and how it should be processed. Minor formatting changes.
3.2	03/12/2019	Updated Section 3.5 to add MBI (Page 16 & Page 17). Updated FAQ 4.3.17 (Page 39) for MBI logic.
3.3	05/26/2020	Updated Section 3 (Page 8) Instruction Tables deleted the 834 Companion Guide web link.