309 MANAGED CARE ORGANIZATIONS 309.1 GENERAL INFORMATION

Introduction

This chapter contains information on processing electronic transactions. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).
The intent of this document is to provide information related to electronic submissions by the Managed Care Organizations (MCOs). This document must be used in conjunction with the following documents:

1. ASCX12 Electronic Data Interchange Transaction Set Implementation Guides and all related Addenda for the following transactions:

    a. 820 – Payroll Deducted and Other Group Premium Payment for Insurance Products
    b. 834 – Benefit Enrollment and Maintenance
    c. 837I – Health Care Claim: Institutional
    d. 837P – Health Care Claim: Professional
    e. 837D – Health Care Claim: Dental

2. National Council for Prescription Drug Programs Telecommunication Standard Version 1.2 (Batch)

3. HFS Companion Guides provided in Chapter 300 of the Provider Handbook

Business Rules

- File will be sent to and retrieved from HFS via Internet FTP.

- HFS will no longer require claim-level provider affiliation information on encounter data transactions (837I, 837P, 837D, NCPDP).

- The “Billing Provider” submitted on encounter data transactions will always be the provider of service.

- When submitting claims to HFS that were previously rejected, the original claim cannot be voided. HFS will not allow a rejected claim to be submitted as a “Void and Rebill”. Only claims that have been paid (accepted) can be voided.

309.2 820 – PAYROLL DEDUCTED AND OTHER GROUP PREMIUM PAYMENT FOR INSURANCE PRODUCTS

309.21 GENERAL INFORMATION

Business Rules

- The 820 transaction will be generated daily.
- The 820 transaction will not be generated at the same time as the 834 Benefit Enrollment and Maintenance Monthly Roster transaction.
- This 820 transaction will be the only "remittance advice" created by HFS for capitation payments. An 835 transaction will not be created for the capitation payment.

309.22 TECHNICAL INFORMATION

This section contains information relating to transmitting information to the Department. This section will identify, down to the data element level, anything unique to the Department in regards to the EDI transaction.

Transmission Information

These files will be retrieved from the Department via Internet FTP.

EDI Information:

The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
35		820 Header	ST02	Transaction Set Control Number	Always “0001”
37		Financial Information	BPR01	Transaction Handling Code	Will be “I”
38		Financial Information	BPR03	Credit/Debit Flag Code	Will be “C”
38		Financial Information	BPR04	Payment Method Code	Will be “NON”
42		Financial Information	BPR16	Date	Will be warrant date or EFT date from Comptroller or “No Input \\\\\\”
43		Reassociation Key	TRN01	Trace Type Code	Will be “3”
43		Reassociation Key	TRN02	Reference Identification	Will be warrant or EFT number from Comptroller
48		Premium Receivers Identification key	REF01	Reference Identification Qualifier	Will be “14”
49		Premium Receivers Identification key	REF02	Reference Identification	Will be the 16-digit parent payee number or FEIN and ‘\\\\\’ when there is no payment
54		Coverage Period	DTM06	Date Time Period	Date range of customary capitation month
56	1000A	Premium Receivers Name	N102	Name	Will be Payee Name
57	1000A	Premium Receivers Name	N103	Identification Code Qualifier	Will be “FI”
57	1000A	Premium Receivers Name	N104	Identification Code	Will be 1st 9-digits of Payee number (FEIN)
64	1000B	Premium Payer’s Name	N102	Name	Will be “ILLINOIS MEDICAID”
65	1000B	Premium Payer’s Name	N103	Identification Code Qualifier	Will be “FI”

IG Page #	Loop	Description	Element ID	Element Name	Remarks
65	1000B	Premium Payer's Name	N104	Identification Code	Will be "37-1320188"
106	2000B	Individual Remittance	ENT01	Assigned Number	Will be a sequential number starting with 1
106	2000B	Individual Remittance	ENT03	Identification Code Qualifier	Will be "EI"
106	2000B	Individual Remittance	ENT04	Identification Code	Will be the Recipient's 9-digit number
107	2100B	Individual Name	NM101	Entity Identifier Code	Will be "IL"
112/113	2300B	Individual Premium Remittance Detail	RMR01	Reference Identification Qualifier	Will be "AZ"
113	2300B	Individual Premium Remittance Detail	RMR02	Reference Identification	8 position procedure code
114	2300B	Reference Information	REF01	Reference Identification Qualifier	Will be 18 (Plan Number)
114	2300B	Reference Information	REF02	Reference Identification	6 digit site number
115	2300B	Individual Coverage Period	DTM01	Date/Time Qualifier	582 (Report Period)
116	2300B	Individual Coverage Period	DTM06	Date Time Period	Will be the first of the service month and the end of the service month
118	2320B	Individual Premium Adjustment	ADX02	Adjustment Reason Code	Will be "52" or "53"

309.3 834 – BENEFIT ENROLLMENT AND MAINTENANCE

309.31 GENERAL INFORMATION

Business Rules

- The 834 transaction will be used in three different capacities. Following is the title as it will be referenced in this document, as well as a brief description of the functionality:
- **Daily Input** – The 834 Daily Input File will be generated by the Client Enrollment Broker and Managed Care Organization (MCO) and will be submitted to HFS. This file will contain the requests for enrollment, disenrollment, site transfer, and gender changes (under age one).
- **Daily Output** – The 834 Daily Output File will be generated by HFS. This file will contain enrollments, disenrollments, site transfers, and demographic changes processed by HFS.
- **Monthly Roster** – This file will be generated by HFS at the end of the month and will contain members enrolled for the following month. No payment, site transfer, or disenrollment information will be included in this file.
- The Daily Output File must be used by the MCOs to track enrollments, disenrollments, site transfers, and demographic changes.
- Member name and demographic changes will only be supplied on the Daily Output File. This information will not be submitted on the Monthly Roster.
- Currently, HFS only captures language information for Spanish-speaking and Spanish-reading members. When applicable, this information will be included in the monthly roster.
- When applicable, open end dates will be passed as 12/31/9999.

309.32 TECHNICAL INFORMATION

This section contains information relating to transmitting information to the Department. This section will identify, down to the data element level, anything unique to the Department in regards to the EDI transaction.

Control Segments/Envelopes (ISA/IEA, GS/GE, ST/SE)
The Department will limit the number of INS segments to 5,000 per ST/SE. The Department strongly recommends that all incoming transactions follow the same guidelines. The Department intends to follow all other recommendations as set forth in corresponding Implementation Guides. This includes recommendations on how many transaction sets may be within a functional group (GS/GE), and how many functional

groups may be within a transmission envelope (ISA/IEA). The Department reserves the right to alter from any of these recommendations at a later date.

Transmission Information

These files will be transmitted to the Department and retrieved from the Department via Internet FTP.

EDI Information:

The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

Unless otherwise noted, field requirements are for all files.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
32		Beginning Segment	BGN01	Transaction Set Purpose Code	Must be: “00” for Daily Input/Output File “15” for resubmission of Daily Input/Output File “22” for Monthly Roster
33		Beginning Segment	BGN02	Reference Identification	MCO Parent Provider Number
34		Beginning Segment	BGN05	Time Code	Will be “CT” when HFS creates Daily Output File or Monthly Roster
35		Beginning Segment	BGN06	Reference Identification	MCO Parent Provider Number when HFS creates Daily Output File and Monthly Roster and if BGN01 is “15” or “22”
35		Beginning Segment	BGN08	Action Code	2 – Change or Update (Input/Output File) 4 – Verify for Monthly Roster (Output File); accept 2 from plans
36		Transaction Set Policy Number	REF02	Reference Identification	MCO Parent Provider Number
37		File Effective Date	DTP01	Date/Time Qualifier	Will be “007” for Monthly Roster
38		Transaction Set Control Totals	QTY01	Quantity Qualifier	Will be “TO”
38		Transaction Set Control Totals	QTY02	Quantity	Number of recipient transactions
39	1000A	Sponsor	N102	Name	Must be “ILLINOIS MEDICAID”

IG Page #	Loop	Description	Element ID	Element Name	Remarks
40	1000A	Sponsor Name	N103	Identification Code Qualifier	Must be "FI"
40	1000A	Sponsor Name	N104	Identification Code	Must be "37-1320188"
42	1000B	Payer	N103	Identification Code Qualifier	Must be "FI"
42	1000B	Payer	N104	Identification Code	First 9 digits of MCO parent provider number
48	2000	Member Level Detail	INS01	Yes/No Condition or Response Code	Must be "Y"
48	2000	Member Level Detail	INS02	Individual Relationship Code	Must be "18"
49	2000	Member Level Detail	INS03	Maintenance Type Code	Must be one of the following values for Daily Input/Output File: "001" Site Transfer, name or Gender Changes "021" (Addition) New Enrollment "024" Cancellation or Termination "025" Reinstatement or "030" Monthly Roster
49	2000	Member Level Detail	INS04	Maintenance Reason Code	See chart below.
51	2000	Member Level Detail	INS05	Benefit Status Code	Must be "A"
53	2000	Member Level Detail	INS08	Employment Status Code	AC (active) on Monthly Roster; AC or TE (terminated) on Daily Output File
55	2000	Subscriber Number	REF02	Reference Identification	Must be the Recipient's 9-digit number
56	2000	Member Policy Number	REF02	Reference Identification	Daily Input/Output File - When BGN08 is 2, old site number/new site number; 1) for new enrollments, only the new site, the old site will be either 6 zeroes or "A" (auto assignment) or "E" (choice) followed by 5 zeroes; 2) for transfers, the old

IG Page #	Loop	Description	Element ID	Element Name	Remarks
					and new site numbers; 3) For disenrollments, the old site will be included and the new site will be zeroes; 4) gender, birthdate, and name changes, only the current site will be included; 5) When BGN08 is 4, only the current site will be included
57	2000	Member Supplemental Identifier	REF01	Reference Identification Qualifier	Always "3H"
57	2000	Member Supplemental Identifier	REF02	Reference Identification	Case ID
59-61	2000	Member Level Dates	DTP01	Date/Time Qualifier	Always 473 (Medicaid begin) and 474 (Medicaid end); both segments included
84	2100A	Member Language	LUI01	Identification Code Qualifier	This segment will be populated on the Monthly Roster when DMG05 is H (Hispanic). Value will always be "LD"
85	2100A	Member Language	LUI02	Identification Code	Value will always be "SPA"
	2100G	Responsible Person			Daily Output File and Monthly Roster only. Recipient who is the case holder will not have a 2100G segment
124	2100G	Responsible Person	NM101	Entity Identifier Code	Always "QD"
124	2100G	Responsible Person	NM103	Name Last or Organization Name	Case Last Name
124	2100G	Responsible Person	NM104	Name First	Case First Name
127	2100G	Responsible Person Communications Numbers	PER03	Communication Number Qualifier	Always "TE"
129	2100G	Responsible Person Street Address	N301	Address Information	Case Address
140	2300	Health	HD01	Maintenance	On daily input/output Files – use

IG Page #	Loop	Description	Element ID	Element Name	Remarks
		Coverage		Type Code	001 (changes) for site transfers 021 (addition) for enrollments 024 (termination) for disenrollments 025 (reinstatement) for changes to open site end dates, and 026 (Correction) for gender, name and birthdate changes; use 030 (audit or compare) for Monthly Roster
141	2300	Health Coverage	HD03	Insurance Line Code	Always “HMO” or “EPO” (MCCNs)
143	2300	Health Coverage Dates	DTP01	Date/Time Qualifier	Always send both 348 (Benefit Begin) and 349 (Benefit End); 12/31/9999 for an open end date.
144	2300	Health Coverage Dates	DTP03	Date/Time Period	Site Begin or End Date

Acceptable Values for INS03 and INS04 on Member Level Detail (Loop 2000)			
NS03	**Maintenance Type Code**	**Acceptable INS04 Values**	**Maintenance Reason Code**
001	Change	25	Change in identifying data elements (age and gender) on Daily Input File or Daily Output File
		XT	Transfer (site transfer) on Daily Input File or Daily Output File
		AI	No Reason Given
021	Addition	02	Birth (systematic enrollment of newborn) on Daily Output File
		28	Initial enrollment (systematic enrollment of all others) on Daily Output File
024	Cancellation or Termination	03	Death on Daily Input File or Daily Output File
		07	Termination of benefits (no longer eligible) on Daily Output File
		14	Voluntary withdrawal (all other disenrollments) on Daily Output File
		43	Change of location (change to noncovered county) on Daily Input File or Daily Output File
		AI	No Reason Given
025	Reinstatement	41	Re-enrollment
030	Audit or Compare	XN	Notification only

309.4 837I – HEALTH CARE CLAIM: INSTITUTIONAL

309.41 TECHNICAL INFORMATION

This section contains information relating to retrieving information from the Department. Additionally, this section will identify, down to the data element level, anything unique to encounter data submitted to the Department in regards to the EDI transaction.

Control Segments/Envelopes (ISA/IEA, GS/GE, ST/SE)
Unless specifically noted, the Department intends to follow all recommendations as set forth in corresponding Implementation Guides. This includes recommendations on how many transactions may be included in any given transaction set (ST/SE), how many transaction sets may be within a functional group (GS/GE), and how many functional groups may be within a transmission envelope (ISA/IEA). The Department reserves the right to alter from any of these recommendations at a later date.

Transmission Information
These files will be transmitted to the Department via Internet FTP.

EDI Information
The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide

IG Page #	Loop	Description	Element ID	Element Name	Remarks
63		Header	BHT06	Transaction Type Code	Must be “RP” for encounter data claims.
72	1000A	Submitter Name	NM109	Identification Code	Must be your Federal Tax Identification Number.
111	2000B	Subscriber Information	SBR09	Claim Filing Indicator Code	Must be “MC”.
176	2300	K3 – File Information	K301	Fixed format Information	Must be “D8”, Claim Receipt Date, “D8”, Claim Paid date or Denied date. Format: K3*D8CCYYMMDDD8CCYYMMDD
294	2300	HI – Condition Information	HI01-2	Condition Code	Condition Code “04” must be used when a claim is administratively denied.
314	2300	HCP – Claim Pricing/Re-pricing Information	HCP01	Pricing Methodology	Must be in 00-14 two digit code

314	2300	HCP – Claim Pricing/Re-pricing Information	HCP02	Re-priced Allowed Amount	Must be the amount paid to the provider.
315	2300	HCP - Claim Pricing/Re-pricing Information	HCP04	Re-pricing Organization Identifier	Must be the administrative denial reason Must be one of the following D0, D1, D2, D3, D4, D5, D6, or D7
315	2300	HCP - Claim Pricing/Re-pricing Information	HCP05	Pricing rate associated with per diem or flat rate repricing	Required only for MMAI plans where the services are presumed to be a covered Medicare service. DO NOT Submit if the plan is not part of the MMAI program or if services are considered Medicaid covered services only.

309.5

837P – HEALTH CARE CLAIM: PROFESSIONAL

309.51

TECHNICAL INFORMATION

This section contains information relating to retrieving information from the Department. Additionally, this section will identify, down to the data element level, anything unique to encounter data submitted to the Department in regards to the EDI transaction.

Control Segments/Envelopes (ISA/IEA, GS/GE, ST/SE)
Unless specifically noted, the Department intends to follow all recommendations as set forth in corresponding Implementation Guides. This includes recommendations on how many transactions may be included in any given transaction set (ST/SE), how many transaction sets may be within a functional group (GS/GE), and how many functional groups may be within a transmission envelope (ISA/IEA). The Department reserves the right to alter from any of these recommendations at a later date.

Transmission Information

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EDI Information
The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
72		Header	BHT06	Transaction Type Code	Must be “RP” for encounter data claims.
75	1000A	Submitter Name	NM109	Identification Code	Must be your Federal Tax Identification Number.
118	2000B	Subscriber Information	SBR09	Claim Filing Indicator Code	Must be “MC”.
412	2400	K3-File Information	K301	Fixed format Information	Must be “D8”, Claim Receipt Date, “D8”, Claim Paid date or Denied date. Format: K3*D8CCYYMMDDD8CCYYMMDD
314	2400	HCP – Claim Pricing / Re-pricing Information	HCP01	Pricing Methodology	Must be in 00-14 two digit pricing methodology codes
314	2400	HCP – Claim Pricing/Re-pricing Information	HCP02	Re-priced Allowed Amount	Must be the amount paid to the provider.
315	2400	HCP - Claim Pricing/Re-pricing Information	HCP04	Re-pricing Organization Identifier	Must be the administrative denial reason Must be one of the following D0, D1, D2, D3, D4, D5, D6, or D7
315	2400	HCP - Claim Pricing/Re-pricing Information	HCP05	Pricing rate associated with per diem or flat rate repricing	Required only for MMAI plans where the services are presumed to be a covered Medicare service. DO NOT Submit if the plan is not part of the MMAI program or if services are considered Medicaid covered services only.

309.6 NCPDP VERSION 1.2 BATCH

Information regarding this section will be made available in the near future.

837D – HEALTH CARE CLAIM: DENTAL

309.7

TECHNICAL INFORMATION

This section contains information relating to retrieving information from the Department. Additionally, this section will identify, down to the data element level, anything unique to encounter data submitted to the Department in regards to the EDI transaction.

Control Segments/Envelopes (ISA/IEA, GS/GE, ST/SE)
Unless specifically noted, the Department intends to follow all recommendations as set forth in corresponding Implementation Guides. This includes recommendations on how many transactions may be included in any given transaction set (ST/SE), how many transaction sets may be within a functional group (GS/GE), and how many functional groups may be within a transmission envelope (ISA/IEA). The Department reserves the right to alter from any of these recommendations at a later date.

Transmission Information

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EDI Information
The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
68		Header	BHT06	Transaction Type Code	Must be “RP” for encounter data claims.
70	1000A	Submitter Name	NM109	Identification Code	Must be your Federal Tax Identification Number.
116	2000B	Subscriber Information	SBR09	Claim Filing Indicator Code	Must be “MC”.
310	2400	K3-File Information	K301	Fixed format Information	Must be “D8”, Claim Receipt Date, “D8”, Claim Paid date or Denied date. Format: K3*D8CCYYMMDDD8CCYYMMDD
312	2400	HCP – Claim Pricing / Re-	HCP01	Pricing Methodology	Must be in 00-14 two digit pricing methodology codes

		pricing Information			
312	2400	HCP – Claim Pricing/Re-pricing Information	HCP02	Re-priced Allowed Amount	Must be the amount paid to the provider.
313	2400	HCP - Claim Pricing/Re-pricing Information	HCP04	Re-pricing Organization Identifier	Must be the administrative denial reason Must be one of the following D0, D1, D2, D3, D4, D5, D6, or D7
313	2400	HCP - Claim Pricing/Re-pricing Information	HCP05	Pricing rate associated with per diem or flat rate repricing	Required only for MMAI plans where the services are presumed to be a covered Medicare service. DO NOT Submit if the plan is not part of the MMAI program or if services are considered Medicaid covered services only.