HEALTHpac 834 Message Elements

Version 1.2

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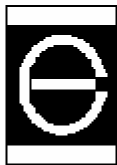
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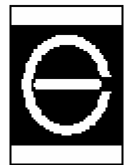

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1 Introduction

1.1 General comments

This document describes the HIPAA 834 standard message elements that are or may be used by HEALTHpac.

In the following tables, fields that have a fixed identifier when used (for instance, an ID code qualifier that, if used, can only have a single value) are not listed.

The columns contain the following:

- Group name – name of the group of segments in the HIPAA specification.
- Item name – name of the element or subelement in the HIPAA specification.
- Loop – loop identifier in the HIPAA specification.
- Seg– name of the segment in the HIPAA specification.
- Pos – position of the element or subelement in the HIPAA specification.
- R/S – Required/Situational indicator from the HIPAA spec; "R*" means the item is required if the segment itself is used, though the segment is Situational.
- Type – element type (AN = alphanumeric, R = real/decimal, ID = ID code, and so on, following the nomenclature in the X12 specification).
- Max – if the maximum field length differs between the HIPAA specification and HEALTHpac, the HIPAA value is listed first and the HEALTHpac value is listed second (e.g., 60/35); otherwise the single (common) length is listed.
- Notes – miscellaneous notes about the use of the item. For brevity, **"CO"** means the item is configurable outbound, and **"II"** means the item is ignored inbound. "Configurable outbound" means the external system can specify what value to use.

HEALTHpac ignores many inbound elements, though syntax checking is done on *all* elements and errors are noted even for elements that HEALTHpac doesn't use.

Both sides of a message exchange must agree on the number of members to include in a file. For HEALTHpac, the restriction is primarily based on memory size restraints.

Another consideration related to batching is the placement of employee and dependent records for new enrollment. The employee must already be defined in HEALTHpac before a record for the dependent is read. Inbound, HEALTHpac will process files based on the file creation date starting with the

oldest file. Outbound, HEALTHpac puts the dependent records for an employee immediately after the employee's record (when both employee and dependent records are being generated), and it insures that all those dependent records are in the same file. .

1.2 Functionality

HEALTHpac can generate benefit enrollment files in the 834 format, and it can process inbound 834 files. When generating files, the HEALTHpac user can specify various filters that restrict the data that is sent, and when receiving files, the HEALTHpac user can specify what types of data are expected and what types of actions are allowed.

Before data is exchanged between HEALTHpac and an external system, both sides must agree about the content of the files; for instance, if a third party system will be sending enrollment information for a major medical policy and nothing else, HEALTHpac must be configured to expect that data and nothing else; otherwise it will terminate all other types of polices and all secondary insurance products because the incoming data doesn't specify such plans and products.

1.2.1 User control of generating 834 files from HEALTHpac

When generating 834 benefit enrollment records, the HEALTHpac user can select the following filters to restrict the output. Multiple filters may be specified (e.g., generate records for employees having a certain benefit status and include only major medical health coverage information).

- Employees and dependents – the user can select to send data for both employees and dependents, just for employees, or just for dependents.
- Group – the user can limit the output to members in a specified group or in all groups for a specified underwriter.
- Plan – the user can specify that eligibility records for only a specified plan be generated.
- Product type – the user can specify that eligibility records for only a specified primary product type be sent.
- Certificate – the user can specify that only members having a specified certificate be selected for the file.
- Benefit status – the user can specify that only members having a specified benefit status for a specified effective date be considered for the file
- ID cards – the user can specify that data related to generating ID cards be generated or not.
- Salary and other administrative information – the user can indicate whether salary and pay frequency be sent or not.
- File effective date and file effective date qualifier – the user can control whether a file effective date be sent and, if so, what qualifier should be used.

When generating benefit enrollment records, the user must specify the effective date to use for generating health coverage records. The beginning effective date for all selected plans and products that are in use by the member on the specified effective date will be taken from that initial HEALTHpac eligibility record; hence, these dates may be earlier than the effective date specified by the user. Beginning eligibility dates for plans and products that appear later will correspond to the dates those HEALTHpac eligibility records. If the plans and products are still in effect at the time the HIPAA records were generated, no termination date will be specified.

If the initial HIPAA benefit (active or COBRA) changes before the last eligibility record in HEALTHpac is read, a termination of benefits date will be created for each plan and product using the effective date of the new eligibility record as the termination date, but no records will be written for the new benefit status. It is assumed that "today's date" will typically be used for the effective date, so this situation shouldn't arise.

1.2.2 User control of processing 834 files sent to HEALTHpac

Before processing inbound 834 files, the user can specify various controls to be used when interpreting the data.

- Creating employee and dependent records – the user can prohibit the creation of new employee and dependent records; alternatively, the user can also specify whether data in existing employee and dependent records can be changed.
- Termination of all benefits – the user can indicate whether or not to honor a member level date specifying the termination of all benefits.
- Product types expected – the user can specify whether all primary insurance products are expected, or whether just certain product types are expected.
- Secondary products expected – the user can specify whether all possible secondary insurance products are expected, or whether just certain ones are expected.
- Primary care physician data expected – the user can specify whether primary care physician data for major medical plans is expected.
- COBRA and Medicare dates – the user can specify whether COBRA start and end dates or Medicare start and end dates are expected.
- Salary data – the user can specify whether salary and pay frequency are expected.

Data that is not marked as 'expected" is ignored. For instance, if only major medical plan information is expected, health coverage records for other types of plans and all secondary insurance products are ignored.

The user can place the HEALTHpac program in "read-only" mode. In this mode, the program merely reports discrepancies between the data on file and what's in the HEALTHpac database.

1.2.3 Primary and secondary insurance products

HEALTHpac can generate health coverage records for both primary and secondary insurance products. Primary products correspond to major medical, dental, vision, prescription drug, short-term disability, and long term disability. The client defines secondary products. These products only apply to the employee (hence, there is no coverage level), and claims cannot be made against them.

In HEALTHpac, the definition record for the secondary product includes the HIPAA line product code to use when generating 834 health coverage records for the product.

1.2.4 Group Numbers and Plan Numbers

Before HEALTHpac and an external system can exchange benefit enrollment records, both sides must agree how to represent group numbers and plan numbers. Further, before reading benefit enrollment files, all groups, products, and plans that may be specified in the 834 records must already exist in HEALTHpac; they will not be created “on the fly”.

1.2.4.1 Group numbers

For HEALTHpac, a group number may appear in two different places in an 834 transaction set. It may appear as the master policy number in the header (REF02 with qualifier “38”), or it may appear in loop 2000 as the member level group number or policy number (REF02 with qualifier “1L”). (It may appear in both places, too.)

Both sides of a message exchange need to know which element will be used to specify the group number.

Two options are possible: either the 6-character HEALTHpac underwriter/group number is used, or the group number is translated between HEALTHpac’s number and a value used by the external system. In the latter instance, the HEALTHpac user must run a table maintenance program in order to specify which external values should be used to represent the various groups.

1.2.4.2 Policy numbers

HEALTHpac assumes (with one exception) that the benefit plan ID will appear in the insured group or policy number field in the health coverage loop 2300 (REF02, qualifier “1L”). There are a number of options for interpreting the policy number.

- Use HEALTHpac benefit plan and product IDs.
- Translate between HEALTHpac benefit plan and product IDs and external system IDs using the underwriter and group.
- Translate between HEALTHpac benefit plan and product IDs and external system IDs without regard to underwriter and group. The implication here is that the same external identifier is used to represent a plan or product regardless of which group the member is enrolled in.
- Use the insurance line type to look up the plan; no explicit policy number will be used. This option only applies to primary insurance plans, and it requires that the HEALTHpac user enter a translation table entry with the reserved word “DEFAULT” as the external system’s ID for the plan.

As with translating group numbers, if a translation is required, the appropriate HEALTHpac translation table records must already be in place before data is exchanged.

1.2.5 Ending dates

Dates representing end of eligibility, COBRA end, and Medicare end, are interpreted as corresponding to the first day the member is *ineligible* for the benefit, not the last day the member is eligible. Hence, if both a beginning and an ending date are specified, the ending date will be strictly greater than the beginning date.

1.3 Related documents

HEALTHpac HIPAA Message Header Elements describes the elements in the ISA and GS segments.

2 Message Elements

2.1 Header

Group Name	Item name	Loop	Seg	Pos	R/S	Type	Max	Notes
Beginning segment	Transaction set purpose code		BGN	01	R	ID	2	II; CO
Beginning segment	Transaction set ID code		BGN	02	R	AN	30	II; CO
Beginning segment	Transaction set creation date		BGN	03	R	DT	8	II
Beginning segment	Transaction set creation time		BGN	04	R	TM	8	II
Beginning segment	Time zone code		BGN	05	S	ID	2	II
Beginning segment	Action code		BGN	08	R	ID	2	CO
Txn set policy number	Master policy number		REF	02	R*	AN	30	Configurable
File effective date	Date/time qualifier		DTP	01	R*	ID	3	II; CO
File effective date	Date time period		DTP	03	R*	AN	35/8	II; CO
Sponsor name	Plan sponsor name	1000A	N1	02	S	AN	60	
Sponsor name	ID code qualifier	1000A	N1	03	R	ID	2	
Payer	Payer name	1000B	N1	02	S	AN	60	II
Payer	ID code qualifier	1000B	N1	03	R	ID	2	II
Payer	Insurer ID code	1000B	N1	04	R	AN	80	II

Group Name	Item name	Loop	Seg	Pos	R/S	Type	Max	Notes
TPA/Broker name	Entity ID code	1000C	N1	01	R*	ID	3	II; “TV” outbound
TPA/Broker name	TPA or broker name	1000C	N1	02	R*	AN	60	II; CO
TPA/Broker name	ID code qualifier	1000C	N1	03	R*	ID	2	II; CO
TPA/Broker name	TPA or broker ID code	1000C	N1	04	R*	AN	80	II; CO
TPA/Broker account info	TPA or broker account #	1100C	ACT	01	R*	AN	35	II; CO

2.2 Member Detail

Group Name	Item name	Loop	Seg	Pos	R/S	Type	Max	Notes
Insured Benefit	Subscriber indicator	2000	INS	01	R	ID	1	
Insured Benefit	Individual relationship code	2000	INS	02	R	ID	2	
Insured Benefit	Maintenance type code	2000	INS	03	R	ID	3	II; CO
Insured Benefit	Maintenance reason code	2000	INS	04	S	ID	3	II; CO
Insured Benefit	Benefit status code	2000	INS	05	R	ID	1	
Insured Benefit	Medicare plan code	2000	INS	06	S	ID	1	
Insured Benefit	COBRA qualifying event code	2000	INS	07	S	ID	2	
Insured Benefit	Employment status code	2000	INS	08	S	ID	2	
Insured Benefit	Student status code	2000	INS	09	S	ID	1	Outbound only “F” and “N” are sent
Insured Benefit	Handicap indicator	2000	INS	10	S	ID	1	
Insured Benefit	Insured individual death date	2000	INS	12	S	AN	35/8	
Insured Benefit	Birth sequence number	2000	INS	17	S	N0	9/2	
Subscriber number	Subscriber ID	2000	REF	02	R	AN	30/20	Qualifier “0F”
Group number	Insured group or policy number	2000	REF	02	R*	AN	30/15	Configurable; qualifier “1L”
Prior Coverage Months	Prior coverage month count	2000	REF	02	R*	AN	30/4	II

Group Name	Item name	Loop	Seg	Pos	R/S	Type	Max	Notes
Member Level Dates	Date time qualifier	2000	DTP	01	R*	ID	3	See below
Member Level Dates	Status information effective date	2000	DTP	03	R*	AN	35/8	
Member Name	Entity ID code	2100A	NM1	01	R	ID	3/2	
Member Name	Member's last name	2100A	NM1	03	R	AN	35	
Member Name	Member's first name	2100A	NM1	04	R	AN	25	
Member Name	Member's middle initial	2100A	NM1	05	S	AN	25/1	
Member Name	Member's name suffix	2100A	NM1	07	S	AN	10/10	
Member Name	ID code qualifier	2100A	NM1	08	S	ID	2	"34" unless prohibited
Member Name	Member's ID	2100A	NM1	09	S	AN	80/30	
Member Communication #s	Communication number qualifier	2100A	PER	03	R*	ID	2	"EM", "HP", or "WP"
Member Communication #s	Communication number	2100A	PER	04	R*	AN	80/40	For "EM" qualifier
Member Communication #s	Communication number	2100A	PER	04	R*	AN	80/20	For "HP" or "WP" qualifiers
Member residence street	Address line 1	2100A	N3	01	R*	AN	55	
Member residence street	Address line 2	2100A	N3	02	R*	AN	55	
Member residence city/state	City name	2100A	N4	01	R*	AN	30	
Member residence city/state	State code	2100A	N4	02	R*	ID	2	
Member residence city/state	Postal code	2100A	N4	03	R*	ID	15/9	

Group Name	Item name	Loop	Seg	Pos	R/S	Type	Max	Notes
Member Demographics	Member birth date	2100A	DMG	02	R*	AN	35/8	
Member Demographics	Member gender code	2100A	DMG	03	R*	ID	1	
Member Demographics	Member marital status	2100A	DMG	04	S	ID	1	
Member Income	Frequency code	2100A	ICM	01	R*	ID	1	
Member Income	Wage amount	2100A	ICM	02	R*	AN	18/12	
Member Health Information	Health-related code	2100A	HLH	01	S	ID	1	HEALTHpac only uses "T"
Incorrect Member Name	Prior incorrect insured last name	2100B	NM1	03	R*	AN	35	Inbound only
Incorrect Member Name	Prior incorrect insured first name	2100B	NM1	04	R*	AN	25	Inbound only
Incorrect Member Name	Prior incorrect insured ID	2100B	NM1	09	S	AN	80/30	Inbound only; assumed to be SSN
Incorrect Member Demographics	Prior incorrect insured birth date	2100B	DMG	02	R*	AN	35/8	Inbound only
Incorrect Member Demographics	Prior incorrect insured gender code	2100B	DMG	03	R*	ID	1	Inbound only
Member School	School name	2100E	NM1	03	R*	AN	35	

The following qualifiers may be used for member level dates: "286" (retirement), "301" (COBRA qualifying event), "338" (Medicare begin), "339" (Medicare end), "340" (COBRA begin), "341" (COBRA end), "357" (eligibility end).

2.3 Health Coverage Information

Group Name	Item name	Loop	Seg	Pos	R/S	Type	Max	Notes
Health Coverage Info	Maintenance type code	2300	HD	01	R*	ID	3	CO
Health Coverage Info	Insurance line code	2300	HD	03	R*	ID	3	See note below
Health Coverage Info	Plan coverage description	2300	HD	04	S	AN	50	II
Health Coverage Info	Coverage level code	2300	HD	05	S	ID	3	See note below
Health Coverage Info	Health coverage date qualifier	2300	DTP	01	R*	ID	3	Qualifiers “348” and “349”
Health Coverage Info	Health coverage date	2300	DTP	03	R*	AN	35/8	
Health Coverage Info	Insured group or policy #	2300	REF	02	R*	AN	30/15	Qualifier “1L”; must be policy or product ID

Outbound, for a primary insurance plan, HEALTHpac uses “MM” for major medical, “DEN” for dental, “VIS” for vision, “PDG” for prescription drug, “STD” for short term disability, and “LTD” for long term disability. The values used for secondary insurance products are established by the HEALTHpac user.

Inbound, a translation table may be configured in HEALTHpac to convert a HIPAA insurance line code into a HEALTHpac product type if the default values used for outbound primary insurance plans do not apply.

Inbound, a translation table may be configured in HEALTHpac to convert HIPAA coverage level codes into HEALTHpac codes. The following HIPAA coverage level codes can be converted to HEALTHpac coverage level codes without an explicit translation table: “EMP”, “FAM”, “ESP”, “E1D”, “E2D”, “SPO”, “CHD”, “SPC”, “ECH”, and “DEP”, though both sides should first verify that they interpret these codes the same way.

2.4 ID Card Request

Group Name	Item name	Loop	Seg	Pos	R/S	Type	Max	Notes
ID card	Plan coverage description	2300	IDC	01	R*	AN	50	
ID card	ID card type code	2300	IDC	02	R*	ID	1	

HEALTHpac can generate requests for ID cards, but it will ignore this information inbound.

2.5 Provider Information

Group Name	Item name	Loop	Seg	Pos	R/S	Type	Max	Notes
Provider name	Entity ID code	2310	NM1	01	R	ID	3/2	Only “P3” is of interest
Provider name	Entity type qualifier	2310	NM1	02	R	ID	1	
Provider name	Provider last name/org name	2310	NM1	03	S	AN	35	
Provider name	Provider first name	2310	NM1	04	S	AN	25	
Provider name	Provider middle initial	2310	NM1	05	S	AN	25/1	
Provider name	Provider name suffix	2310	NM1	07	S	N	10	
Provider name	ID code qualifier	2310	NM1	08	S	ID	2	
Provider name	Provider ID	2310	NM1	09	S	AN	80/20	Required by HEALTHpac
Provider city, state, ZIP	City name	2310	N4	01	R*	AN	30	
Provider city, state, ZIP	State code	2310	N4	02	R*	ID	2	
Provider city, state, ZIP	Postal code	2310	N4	03	R*	ID	15/9	

2.6 COB

Group Name	Item name	Loop	Seg	Pos	R/S	Type	Max	Notes
COB	Payer responsibility	2320	COB	01	R*	ID	1	II; “P” outbound
COB	COB code	2320	COB	02	R*	ID	1	II
COB	Additional COB ID qualifier	2320	REF	01	R*	ID	2	II; “SY” if allowed
COB	Additional COB ID	2320	REF	02	R*	AN	35/15	II
Other insurance company name	Insurer name	2320	N1	02	S	AN	60	II
Other insurance company name	ID code qualifier	2320	N1	03	S	ID	2	II
Other insurance company name	Insured group or policy #	2320	N1	04	S	AN	80/15	
Other payer name	Other payer ID qualifier	2330B	NM1	08	R	ID	2	II; outbound set to “PI”
Other payer name	Other payer primary ID	2330B	NM1	09	R	AN	80/9	

Inbound, COB records are ignored.