

# CALIFORNIA MEDI-CAL

HIPAA – EDI Health Care  
Eligibility, Coverage or Benefit Inquiry and Response

## HS 270 and HB 271 Transaction Sets

Eligibility Inquiry – 4010A1 Implementation Format  
Spend Down (SD) and SD Reversals – 4010 Standard Format  
Medical Services Reservation (MSR) and MSR Reversals – 4010 Standard Format

270/271 Overview for Leased-Line, Dial-Up and Batch Submissions

- - - Companion Guide - - -

EDS for Medi-Cal  
Created June 15, 2004  
Last Updated May 15, 2007

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# Change Log

Date	Page	Loop/ Txn	Segment/ Element ID	Segment Name	Data Element/Field Name (Industry)	Description
6/15/2004	N/A	N/A	N/A	N/A	N/A	First published.
6/22/2004	9	N/A	N/A	N/A	N/A	Example transaction updated.
	11	2100A	N/A	N/A	NM101	Changed "is not 1P" to "is not PR."
	12	2100C	N/A	N/A	NM101	Changed "is not PR" to "is not IL."
9/21/2004	3	N/A	N/A	N/A	N/A	Changed "Benefit Response" to "Benefit Information Response."
		N/A	N/A	N/A	N/A	Changed "...which requests benefit eligibility information..." to "...which requests health care eligibility information..."
	4	N/A	N/A	N/A	N/A	In New Terminology table, changed "Spend Down Amount (SOC)" to "SOC (Spend Down)."
	6	N/A	N/A	N/A	N/A	Added "...in the currently accepted format" to the note.
	8	N/A	N/A	N/A	N/A	In "TM – Time" format type description, "d..d" portion of time format changed to "DD".
	9	N/A	N/A	N/A	N/A	In example, all instances of "Hex'0D" changed to "X'0D".
		N/A	N/A	N/A	N/A	In last sentence of second paragraph under "Delimiters and Terminators" heading, changed "The following delimiter and terminator are used..." to "The following are used..."
	10	N/A	N/A	N/A	N/A	Removed second sentence of first paragraph.
	11 – 13	N/A	N/A	N/A	N/A	Table of Appendix A updated in its entirety.
11/15/04	Cover page	N/A	N/A	N/A	N/A	Changed subtitle to "Overview for Leased-Line and Dial-Up Submissions".
	2, 3, 4, 7	N/A	N/A	N/A	N/A	Changed "Customer Information Control System (CICS) Inter-System Communication (ISC)" to "dial-up".
	5	N/A	N/A	N/A	N/A	Renamed soon-to-be-published document.
	6	N/A	N/A	N/A	N/A	Page updated in its entirety to describe the voluntary and mandatory system testing procedures.
	10	N/A	N/A	N/A	N/A	Added reference to the <i>Identification Cards Magnetic Stripe Format</i> supplemental document scheduled to be published in December 2004.
12/09/04	6	N/A	N/A	N/A	N/A	"Mandatory Testing" section updated to reflect existence of new <i>270/ 271 Transactions Test Data</i> document. Instruction to reference Companion Guide to format transactions changed to reference Implementation Guide and Standard.
5/23/05	Cover page	N/A	N/A	N/A	N/A	Added Batch Submissions to the Leased-Line & Dial-Up.
	8	N/A	N/A	N/A	N/A	Added a section for Batch System Testing.
	13 – 17	N/A	N/A	N/A	N/A	Added some AAA Rejection Codes unique to Batch.
5/15/2007	3, 4, 5, 6, 11, 13, 14	N/A	N/A	N/A	N/A	Changed all "DHS" references to "CDHS." (The acronym has been changed from "DHS" to "CDHS").
	8, 9, 10, 12, 14	N/A	N/A	N/A	N/A	Changed "Companion Guides page" to the correct title of the page on the Medi-Cal Web site: "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" page
	4	N/A	N/A	N/A	N/A	Added update for the NPI Final Rule and

						Medi-Cal's Dual-Use and NPI Implementation information to the introduction. Corrected the "HIPAA UPDATES" link to "HIPAA" link.
6	N/A	N/A	N/A	N/A	N/A	Added definition of NPI and Medicaid Provider ID to the "New Terminology" table.
7	N/A	N/A	N/A	N/A	N/A	Corrected instructions to find the <i>Medi-Cal Point of Service (POS) Network Telecommunications Interface Standards, Third Party Vendors</i> document on the Web site.
8	N/A	N/A	N/A	N/A	N/A	Added additional information for NPI and Medi-Cal provider number mandatory testing.
9	N/A	N/A	N/A	N/A	N/A	Added additional information for NPI and Medi-Cal provider number testing. Changed sentence to cannot submit 30XX format transactions. Removed sentence for using own submitter/provider ID for Voluntary testing.
14	N/A	N/A	N/A	N/A	N/A	Added new section – NPI Check-Digit Algorithms.
14	N/A	N/A	N/A	N/A	N/A	Corrected instructions to find the <i>Medi-Cal Identification Cards Magnetic Stripe Formats</i> document on the Web site.
Appendix A	N/A	N/A	N/A	N/A	N/A	Added 'XX' to 2100B NM108 values to table. Corrected invalid/incorrect information in appendix. Corrected format of the table.
10/18/2007	All pages	N/A	N/A	N/A	N/A	Changed all Department of Health Services (CDHS) references to Department of Health Care Services (DHCS).

# Disclaimer

## Purpose of the ANSI ASC X12N 270/271 Eligibility Benefit Inquiry/Response Transactions Companion Guide

This Companion Guide for the ANSI ASC X12N 270/271 transaction has been created for use with the ASC X12N 270/271 Implementation Guide. It should not be considered a replacement for the Implementation Guide, but rather used as an additional source of information. This Companion Guide contains data clarifications derived from specific business rules that apply exclusively to Medicaid processing for the California Medi-Cal Program of the State of California Health and Human Services Agency – Department of Health Care Services (DHCS). This guide also includes information about sending and receiving data to and from DHCS using leased-line, dial-up & Batch submissions. Submitters are advised that updates to the DHCS Medi-Cal Companion Guides will be made on an ongoing basis. Submitters are therefore encouraged to check the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) periodically for updates to the Companion Guides.

# Introduction

## HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA, Title II) of 1996 require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans and employers. The provisions also address the security and privacy of health data. The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by processes that included significant public and private sector input.

Covered entities are required to accept HIPAA transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both DHCS and its providers are HIPAA-covered entities.

In accordance with the HIPAA Final Rule (45 CFR Part 162), the National Provider Identifier (NPI) was named the standard unique identifier for health care providers. After May 23, 2007 (the NPI compliance date), health plans can no longer require providers to supply any identifier other than the NPI to process standard electronic transactions. However, Medi-Cal has decided to have a dual-use period for the submission of the 270 transactions as explained below:

**NPI Dual-Use Period:** Medi-Cal will have a dual-use period for the NPI where providers will be encouraged to send both the NPI and the Medi-Cal provider number for certain types of transactions. However, for the 270 Eligibility Inquiry Request, Spend Down Request, Spend Down Reversal, Medical Services Reservation and Medical Services Reservation Reversal transactions, only the Medi-Cal provider number (not the NPI) will be accepted until Medi-Cal fully implements and mandates the use of the NPI.

**NPI Implementation:** Once the NPI is mandated for use and implemented by Medi-Cal, only the NPI will be accepted and processed for all transactions with the following exceptions:

- The Medi-Cal provider number must be used if a provider does not qualify for an NPI (atypical providers) for both Reservations and Reversals.
- The Medi-Cal provider number must be used to reverse a Medical Services Reservation for Reservations originally created with the Medi-Cal provider number, even if the provider requires/has an NPI.
- The Medi-Cal provider number must be used to reverse a Spend Down Request originally created with the Medi-Cal provider number, even if the provider requires/has an NPI.

Updates to the Medi-Cal companion guides include the NPI usage information.

## Companion Guides – Data Specifications

Companion Guides are available to external entities (health plans, program contractors, providers, third-party processors and billing services) to clarify information about HIPAA-compliant electronic interfaces with DHCS. The following data specifications are included in this companion guide. All are available on the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov); click the “HIPAA” link, then the “ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications” link.

#### Eligibility, Coverage or Benefit Inquiry:

- HS/270 Eligibility Inquiry – 4010A1 Implementation Format
- HS/270 Medical Services Reservation (MSR) and MSR Reversals – 4010 Standard Format
- HS/270 Spend Down (SD) and SD Reversals – 4010 Standard Format

#### Eligibility, Coverage or Benefit Information Response:

- HB/271 Eligibility Inquiry – 4010A1 Implementation Format
- HB/271 Medical Services Reservation (MSR) and MSR Reversals – 4010 Standard Format
- HB/271 Spend Down (SD) and SD Reversals – 4010 Standard Format

The 270 transaction, which requests health care eligibility information, will be submitted to DHCS for processing. DHCS validates submission of ASC X12N format(s). If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported in AAA Segments, and in the case of Batch submissions there may be TA1 and 997 Acknowledgements in addition to AAA Segments. The AAA Segments and TA1/997 Acknowledgements are used to report corrupt data or an invalid trading partner relationship. For more information, refer to “Segments” in the *Data Specifications Overview* section of this document.

## Guide Objective

This Companion Guide provides information about leased-line, dial-up and Batch 270 Eligibility Request and 271 Eligibility Response transactions that are specific to DHCS trading partners. For these transactions, this guide describes the data submitted to DHCS by providers and other trading partners when they make electronic eligibility requests, as well as the data sent by DHCS in response. Intended users of this guide are technical staff of external entities that is responsible for electronic transaction/file exchanges.

## Relationship to HIPAA Implementation Guides

Companion Guides supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Detailed rules for format, content and field values can be found in the Implementation Guides. This guide describes the DHCS leased-line and dial-up environment interchange conventions. It also provides specific information about the fields and values required for transactions sent to or received from DHCS.

Companion Guides are intended to supplement, rather than replace, the standard HIPAA Implementation Guide for each transaction set. Information in the Companion Guide does not:

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

## New Terminology

New terminology accompanies the implementation of these new transactions. For example, a patient is now referred to as a “subscriber” rather than as a “recipient.”

Previous Term	New Term
Billed Amount	Total Claim Charge Amount
Date of Birth	Subscriber Birth Date
Date of Card Issue	Issue Date
Date of Service	Service Date
Eligibility Verification Number	Trace Number (Eligibility Verification Confirmation [EVC] Number)
First Name	Subscriber First Name
Last Name	Subscriber Last Name
MEDI Services	Medical Services Reservation
Provider Name	Information Receiver Name (Provider Name)
Provider Number	Service Provider Number
Recipient	Subscriber
Recipient ID	Subscriber ID
Scope of Coverage	Service Type (Scope of Coverage)
Share of Cost (SOC)	SOC (Spend Down)
<b>N/A</b>	<b>National Provider Identifier (NPI)</b>

## Final Authority

The ASC X12N 270/271 (004010X092A1) Implementation Guide is used as the format standard for the 270 Eligibility Inquiry and 271 Eligibility Response.

The ASC X12N 270/271 (004010X092) Standards Guide is used as the format standard for the 270/271 Share of Cost/Spend Down and the 270/271 Share of Cost Reversal/Spend Down Reversal transactions.

The ASC X12N 270/271 (004010X092) Standards Guide is used as the format standard for the 270/271 Medical Services Reservation and the 270/271 Medical Services Reservation Reversal transactions.

**Note:** The above reference guides were used as the source for this companion guide.

# **Third-Party Dial-Up and Leased-Line Network Transmission Protocol Instructions**

Instructions for third-party dial-up and leased-line network transmission protocols are contained in the document *Medi-Cal Point of Service (POS) Network Telecommunications Interface Standards, Third Party Vendors*, which is available on the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). To access the document, click the “Technical Specs” link, then the “*Medi-Cal POS Network Telecommunications Interface Standards, Third Party Vendors*” link.

## **Third-Party Batch Submission Instructions**

Third-party Batch submissions require transactions prepared using any plain text editor, such as Microsoft Windows Notepad, that are uploaded to the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) for evening processing. There is one URL for submission of test transactions and another for submission of production transactions.

# **System Testing - Dial-Up and Leased-Line**

## **Provider/Submitter Testing Procedures**

This section describes the testing procedures required by EDS to ensure accurate transaction format, completeness and validity. There are two types of testing: voluntary and mandatory testing.

For mandatory and voluntary testing, there are separate tests with test data supplied by Medi-Cal for transactions submitted with an NPI and a Medi-Cal provider number. For both types of IDs, a submitter must submit and pass the specific testing for each type of ID before they will be allowed to submit actual production 270 transactions for the ID type being tested.

### **Voluntary Testing**

Testing the new Dial-Up & Leased-Line 4010 format within the Medi-Cal System Test region is voluntary. Depending on the specific vendor hardware and network configurations, a change may be required to enable the vendor system to interconnect through HHSDC to the Medi-Cal System Test environment. This applies only to a Leased Line connection. The Dial-Up environment has a physically separated test system that uses a different telephone number than the production system. Regardless of whether a Leased Line or a Dial-Up connection is used, the vendor should contact the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555 (border providers and out-of-state billers billing for in-state providers, call [916] 636-1200). Additional minor changes must also be made to the Medi-Cal system and require the assistance of the Medi-Cal Systems Group, which will be engaged in the testing process by the Medi-Cal TSC. This voluntary testing process is currently available.

Providers and submitters who wish to test the 270/271 Eligibility transactions using the 4010/4010A1 format should contact the TSC and select the prompt for POS/Internet inquiries. The TSC is available seven days a week, from 6 a.m. to midnight. Providers/submitters will be contacted by Medi-Cal systems support staff, who will explain how to submit the subscriber test data for the 270 Eligibility Inquiry transactions and assist providers/submitters with errors associated with failed transactions.

## Mandatory Testing

Testing the 270 4010 Dial-Up & Leased-Line Eligibility transaction is mandatory. Test data can be obtained from the document titled *270/271 Transactions Test Data*, located under the “Supplemental Documents” heading of the 270/271 section on the “ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications” page of the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)). This document contains testing data for both an NPI and a Medi-Cal provider number. Up to five test transactions must be performed, one for each type of Eligibility transaction. After obtaining the test data, providers/submitters must contact the TSC at 1-800-541-5555 (border providers and out-of-state billers billing for in-state providers, call [916] 636-1200), select the prompt for POS/Internet inquiries and inform the operator they wish to test the 270 4010 Eligibility transaction. They must also give the operator their three-character submitter ID and four-character 4010 software version number (a different four-character software version number must be used to differentiate between the two types of provider IDs being used). The operator will enter a status of “T” in the production region, which will allow the provider/submitter to perform test transactions (using the test data obtained from the *270/271 Transactions Test Data* document) to ensure the submitted format is correct. Test data must be submitted to the production region.

Each failed test transaction is inspected thoroughly by the Systems Group to determine where format errors exist. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, to simulate a production environment, Medi-Cal requests that providers/submitters only send transmission data contained in the *270/271 Transactions Test Data* document. The number of test transmissions depends on the number of format errors and the relative severity of these errors.

Providers/submitters must use the HIPAA Implementation Guide and Standard as published by ASC X12 as the reference to format the 270/271 Eligibility Inquiry/Response transactions. The Medi-Cal companion guides published on the Medi-Cal Web site are available to assist providers/submitters in formatting the 270/271 Eligibility Inquiry/Response transactions to Medi-Cal’s usage and specifications. It takes up to 24 hours for Medi-Cal to verify the accuracy of the test data. Providers/submitters must call the TSC to obtain the test results. If any of the five test transactions fail, the errors must be corrected and all five transactions must be resubmitted. Once successful testing is completed, the TSC operator will change the production region status from “T” to “A”, which will allow production data to flow in to the Medi-Cal system. (Without a status of “A”, the 4010 production transactions will be rejected for an invalid software version number.) Providers/submitters cannot use the 30xx software version or send 30xx-formatted Eligibility transactions

**Note:** Subscriber test data submitted under the voluntary and mandatory testing will not be processed by the production system and will only be used for testing purposes.

All questions should be directed to the TSC at 1-800-541-5555 (border providers and out-of-state billers billing for in-state providers, call [916] 636-1200).

# System Testing - Batch

## Provider/Submitter Testing Procedures

This section describes the testing procedures required by EDS to ensure accurate transaction format, completeness and validity.

### Mandatory Testing

Testing the 270 4010 Batch Eligibility transaction is mandatory. Test data information can be obtained from the document titled *Batch Internet Eligibility Test Transaction Instructions For ASC X12 270/271(004010X092A1) Submissions*, located under the “Supplemental Documents” heading of the 270/271 section on the “ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications” page of the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)). One test transaction batch must

be performed, which will contain one Source, one Receiver and 12 Subscriber loops within the Interchange Envelope. After preparing the test transaction, you do not have to contact the TSC to adjust your status as with Dial-Up or Leased-Line testing. Instead, simply upload the transaction batch via the Medi-Cal Web site and wait for the response (typically one hour for an Acknowledgement and the next day for a 271 Response). As with Dial-Up and Leased-Line, you will be providing in the test transaction your Submitter ID, a dummy Provider ID, and dummy Subscriber IDs. The submission status (“T”est or “P”roduction) will be automatically set - start with a “T” and this will change to a “P” if the test is successful. Each failed test transaction is inspected thoroughly by the Systems Group to determine where format errors exist. Testing is conducted to verify the integrity of the format, not the integrity of the data. Providers/submitters must use the Implementation Guide and Standard as published by ASC X12 as the reference to format the 270/271 Eligibility Inquiry/Response transactions. The Medi-Cal Companion Guides published on the Medi-Cal Web site are available to assist providers/submitters in formatting the 270/271 Eligibility Inquiry/Response transactions to Medi-Cal’s usage and specifications.

All questions should be directed to the TSC at 1-800-541-5555 (border providers and out-of-state billers billing for in-state providers, call [916] 636-1200).

# Data Specifications Overview

## Purposes of Specifications

The purposes of the transaction specifications are to define the data elements and code set values that DHCS allows between trading partners and to specify the type and format of transaction information. In some cases the values specified are subsets of the data element values listed or referenced in the Implementation Guides. In others, they are specific to DHCS requirements. For example, in the Information Source Loop of a transaction in the Implementation Guide, Data Element NM109 is defined as an Identification Code between 2 and 80 characters long. In these transaction specifications, NM109 is defined as the DHCS ETIN Number (610442) and the data element length is from 2 to 15 characters.

Specifications for the 270 and 271 transactions accommodate both leased-line and dial-up transaction submissions and responses. Transaction responses with error conditions return code set values in AAA segments (i.e.; rejection information), and for Batch-TA1 & 997 acknowledgements may be returned in addition to AAA segments.

The information in the data specifications does not: (1) modify the definition, data condition or use of any data element or segment in the standard Implementation Guides; (2) add any additional data elements or segments to the defined data set; (3) utilize any code or data values that are not valid in the standard Implementation Guides; or (4) change the meaning or intent of any implementation specifications in the standard Implementation Guides.

## General Transaction Formatting Information

The 270/271 transactions (inquiries and responses) consist of data elements that are grouped into segments, which in turn are grouped into either a heading or summary section, or grouped into loops. This grouping or nesting is different for each of the six transaction types specified in these technical specifications. The data element groupings or structures are illustrated on page 3 of each technical specification.

## Data Elements

Data elements can be required or situational, fixed in length or variable, and are each a specified type of data element that can repeat. The usage, length, type and occurrence are all documented with each data element in the technical specifications. Along with most data elements, there are codes from which to choose (in the case of inquiries) or that will be returned (in the case of responses). Alternatively, each data element may have a “Medi-Cal Note” specifying what Medi-Cal expects will be returned in a response.

Below are the various data element format types used. More information can be referenced in the Implementation Guide, beginning on page A.4.

<b><u>Format Type</u></b>	<b><u>Symbols</u></b>
Nn	Numeric
R	Decimal & \$\$
ID	Identifier
AN	String
DT	Date
TM	Time

### **Format Type Descriptions**

*Nn – Numeric:* The data elements may be defined to include a decimal point, which may be fixed in location (a value between 0 and 9) counting from the right designated by “n”. The decimal point is not transmitted with the data. The data is right justified.

*R – Decimal Number:* A numeric value containing an explicit decimal point. The decimal point must appear as part of the data stream if it is located at any place other than the right-most end of the number. If a decimal point is not included in the number, none will be assumed. Do not use commas in the decimal number.

*ID – Identifier:* A specific code taken from a predefined list of codes maintained by the Accredited Standards Committee (ASC) X12 or some other body recognized by the committee. The ID codes that will be accepted for Medi-Cal billing are shown as literals within double quotes in the “Values” column for each data element of ID type.

*AN – String:* Any characters from the basic or extended characters set. The Basic Characters Set is defined as:

- Uppercase letters: A through Z
- Digits: 0 through 9
- Special characters: ! " & ' ( ) \* + , - . / : ; ? =
- Space character

The Extended Characters Set is defined as:

- Lowercase letters: a through z
- Special characters: % ~ @ [ ] \_ { } \ | < > # \$

At least one non-space character is required. The significant characters should be left justified. Trailing spaces should be suppressed unless the field is fixed-length.

*DT – Date:* Used to express the standard date in either YYMMDD or CCYYMMDD format, in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12) and DD is the day in the month (01 to 31).

*TM – Time:* Used to express the ISO standard time HHMMSSDD format, in which HH is the hour for a 24-hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and DD is decimal seconds.

Where two numbers are separated by a slash (/), the first number is the minimum allowable length for the field and the second number is the maximum allowable length for the field. Where there is only one number, the length of the field is fixed. Larger fields within the ASC standards will be accepted, but will be truncated on the right if the field is alpha-numeric and on the left if the field is numeric.

## Segments

Segments can be required or situational, and they can repeat. The usage and occurrence are documented with each segment in the technical specifications. Along with each segment is an example of a data stream using the data elements within each segment. More examples can be referenced in the Implementation Guide, beginning on page 343.

### *AAA Segments*

The AAA Request Validation segment is used to identify why a response transaction has not been generated; in essence, why the 270 Eligibility, Coverage or Benefit Inquiry has been rejected. Typically, the AAA segment is generated as a result of either an error in the data (e.g., missing Subscriber ID) or no matching information in the database (e.g., subscriber not found). One other use of the AAA segment is to identify a problem with the processing system itself (e.g., the information source’s system is down).

There are three elements used in the AAA segment. AAA01 is a yes/no indicator and identifies whether the data content was valid. AAA02 is not used. AAA03 is a Reject Reason Code and identifies why the transaction or a data element is invalid. AAA04 is a Follow-up Action Code and identifies what further action should be taken.

More information can be referenced in the Implementation Guide, beginning on page 23.

AAA Segments, TA1 & 997 Acknowledgments - more information on these responses can be found in the documents: *271 Eligibility Response Transaction AAA Segment Error Resolution Process*, and *270 Batch Eligibility Submission Acknowledgement: TA1 & 997*. These are located under the “Supplemental Documents” heading of the 270/271 section on the “ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications” page of the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)).

## Loops

Loops can be mandatory or optional, and can repeat. The use and occurrence are documented on each loop page in the technical specifications. Along with each loop is a list of the segments or sub-loops that comprise it.

Each loop within a transaction represents a grouping of segments pertaining to the information source (Medi-Cal), the information receiver (the provider or clearinghouse), or the subscriber. Loops are documented as loop A, B or C to represent the source, receiver or subscriber, respectively. Alternatively, the loop occurrence can be represented as: first (source), second (receiver) and third (subscriber).

## Excluded Data Elements and Segments

Data elements documented as required are only mandatory if the segment is used. If a segment is situational and is not used, then any required data elements therein are not mandatory. Those data elements are only mandatory if the segment is used.

## Complete Transaction Example

Each technical specification has examples of transaction data streams at the segment level. Below is a complete transaction data stream example for a 270 Eligibility Inquiry transaction, which is a combination of all the appropriate segments. Spaces (variable information) in the examples are represented by periods (.) for clarity.

Example:

```
ISA*03*.....*01*.....*ZZ*.....*ZZ*610442EDS214...*YYMMDD*HHMM*U*00401*.....*0*P~(X'0
D')GS*HS*.....*601442*CCYYMMDD*HHMMSSDD*.....*X*004010X092A1(X'0D')ST*270*.....
.(X'0D')BHT*0022*13*.....*CCYYMMDD*HHMMSSDD(X'0D')HL*1**20*1(X'0D')NM1*P
R*2*Medi-Cal*****46*610442(X'0D')HL*2*1*21*1(X'0D')NM1*1P*1**.....****SV*.....(X'0D')
HL*3*2*22*0(X'0D')TRN*1*.....*1.....*(X'0D')NM1*IL*1*****
MI*.....(X'0D')REF*A6*.....(X'0D')DMG*D8*CCYYMMDD(X'0D')DTP*102*D8*C
CYYMMDD(X'0D')EQ*30(X'0D')SE*.....*(X'0D')GE*1*.....(X'0D')IEA*2*.....(X'0D')
```

## Delimiters and Terminators

A delimiter is a character used to separate two data elements (or sub-elements), and a terminator is used to terminate a segment. Delimiters and terminators are integral parts of the data and are specified in the interchange header segment (ISA). They are explained on page 2 of each technical specification document.

A data element delimiter (also referred to as a separator) will always be used after or in place of each data element. Exceptions to this are that delimiters are not used in place of trailing data elements (refer to page 2 of each technical specification document), and the last data element used is followed only by a segment terminator. The following are used in inquiry and response transaction examples:

X'0D' segment terminator

\* Asterisk data element delimiter/separator

~ Tilde sub-element separator (specified but not used)

## Submitter Software Versions

Submitters must enter their three-character submitter (software vendor) ID, followed by their four-character software version number in ISA02. Medi-Cal/DHCS has the ability to deactivate certain software versions when necessary, thus rejecting transactions.

## Identification Cards Standards and Check-Digit Algorithms

Each Medi-Cal or Denti-Cal subscriber receives a Benefits Identification Card (BIC), a plastic identification card that contains a three-track magnetic stripe. The magnetic-stripe format is based on standards endorsed by the American National Standards Institute (ANSI) and the International Standards Organization (ISO). Refer to the *Medi-Cal Identification Cards Magnetic Stripe Formats* supplemental document, available on the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). To access the document, click the “Technical Specs” link, then the “*Medi-Cal Identification Cards Magnetic Stripe Formats*” link.

Transactions sent through the Medi-Cal POS system will contain the Beneficiary Identification (BID), the Medi-Cal Eligibility Determination System (MEDS) ID or the Client Index Number (CIN). Internal to the transaction-generation software is the subscriber ID check-digit calculation, which can be used to verify the accuracy of an ID that includes the check digit (i.e., 15-digit BID, MEDS or CIN). The CIN uses the same check-digit algorithm as the MEDS ID. More information about these algorithms is contained in the *Check Digit Algorithms* document, which is located under the “Supplemental Documents” heading of the 270/271 section on the “ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications” page of the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).

## National Provider Identifier – Check-Digit Algorithm

When an NPI is used as a card issuer identifier on a standard health identification card, it is preceded by the prefix 80840, in which 80 indicates health applications and 840 indicates the United States. The prefix is required only when the NPI is used as a card issuer identifier. However, in order that any NPI could be used as a card issuer identifier on a standard health identification card, the check digit will always be calculated as if the prefix is present. The National Provider Identifier check digit is calculated using the Luhn formula for computing the modulus 10 “double-add-double” check digit. This algorithm is recognized as an ISO standard and is the specified check digit algorithm to be used for the card issuer identifier on a standard health identification card. Refer to the *Check Digit Algorithms* document located under the “Supplemental Documents” heading of the 270/271 section on the “ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications” page of the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).

## Provider Mail - only with Dial-Up and Leased-Line

Within the Interchange Control Transmission (between the ISA and IEA segments) are functional groups. For an inquiry, there will be only one functional group, the HS group, which contains the 270 Inquiry transaction. However, for a response there will always be two functional groups: HB (response), which contains the 271 Response transaction, and TX (provider mail), which contains the 864 Provider Mail transaction.

A Provider Mail transaction will always be returned with system messages, and one such message will always be the System Down Time.

The layout for the TX/864 functional group or transaction set is contained in the document *Provider Mail: TX Functional Group or 864 Transaction Set*, which is located under the “Supplemental Documents” heading of the 270/271 section on the “ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications” page of the Medi-Cal Web site at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).

# Appendix A: AAA Segment Error Processor Table

The following table describes errors that may be detected in the inbound 270 X12 4010 transactions and the level at which they occur. The AAA segment(s) are returned in the outbound 271 transaction when appropriate.

Loop Level	Data Element	271 Response AAA Segment	Expected Value	Detected Value
2000A	ISA02 Bad Vendor ID / Software Vers #	AAA01	Y/N Response Code	N
		<u>AAA03</u>	<u>Reject Reason Code</u>	<u>41: Authorization Restrictions</u>
		<u>AAA04</u>	<u>C: Please Correct and Resubmit</u>	<u>C</u>
	ISA04 PIN number not found, or not present, or is Invalid <b>ON-LINE ONLY</b>	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	41: Authorization/ Access Restrictions
		AAA04	C: Please Correct and Resubmit	C
	ISA06 Provider number not found, or not present, or is inactive <b>ON-LINE ONLY</b>	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	41: Authorization/ Access Restrictions
		AAA04	C: Please Correct and Resubmit	C
	<u>ISA06</u> <u>Submitter/Provider</u> <u>ID not</u> <u>found, or not</u> <u>present, or is</u> <u>inactive</u> <b>BATCH ONLY</b>	<u>AAA01</u>	<u>Y/N Response Code</u>	<u>N</u>
		<u>AAA03</u>	<u>Reject Reason Code</u>	<u>41: Authorization/ Access Restrictions</u>
		<u>AAA04</u>	<u>C: Please Correct and Resubmit</u>	<u>C</u>
	ISA08 ETIN is not 610442	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	79: Invalid Participation Identification
		AAA04	C: Please Correct and Resubmit	C
System problem		AAA01	Y/N Response Code	Y
		AAA03	Reject Reason Code	42: Unable to Respond at Current Time
		AAA04	R: Resubmission Allowed	R
2100A	NM101 is <b>not present or is</b> <b>filled with spaces</b>	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	T4: Payer Name or Identifier Missing
		AAA04	C: Please Correct and Resubmit	C
	<u>NM101</u> <u>is not PR</u>	<u>AAA01</u>	<u>Y/N Response Code</u>	<u>N</u>
		<u>AAA03</u>	<u>Reject Reason Code</u>	<u>79: Invalid Participation Identification</u>
		<u>AAA04</u>	<u>C: Please Correct and Resubmit</u>	<u>C</u>
	NM108 is not 46	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	79: Invalid Participation Identification
		AAA04	C: Please Correct and Resubmit	C

Loop Level	Data Element	271 Response AAA Segment	Expected Value	Detected Value
	NM109 does not contain 610442	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	79: Invalid Participation Identification
		AAA04	C: Please Correct and Resubmit	C
	<b><u>NM109 not present or is filled with spaces</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>T4: Payer Name or Identifier Missing</u></b>
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>
	System not available	AAA01	Y/N Response Code	Y
		AAA03	Reject Reason Code	42: Unable to Respond at Current Time
		AAA04	R: Resubmission Allowed	R
2100B	NM101 is not 1P	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	<b><u>15: Required application data missing</u></b>
		AAA04	C: Please Correct and Resubmit	C
	NM102 is not 1 or 2	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	<b><u>15: Required application data missing</u></b>
		AAA04	C: Please Correct and Resubmit	C
	NM108 is not SV <b><u>or XX</u></b>	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	<b><u>15: Required application data missing</u></b>
		AAA04	C: Please Correct and Resubmit	C
	NM109 is not present	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	43: Invalid/Missing Provider Identification
		AAA04	C: Please Correct and Resubmit	C
	NM109 is present but not on file	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	51: Provider Not on File
		AAA04	C: Please Correct and Resubmit	C
	NM109 is present and on file but is not active	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	50: Provider ineligible for inquiries
		AAA04	C: Please Correct and Resubmit	C
	<b><u>NM109 does not match ISA06</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>43: Invalid/Missing Provider Identification</u></b>
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>
	<b><u>ONLINE ONLY</u></b>	<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>
	<b><u>REF01 not 4A</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>15: Required application data missing</u></b>
	<b><u>BATCH ONLY</u></b>	<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>
	<b><u>REF02 is not present or</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>

Loop Level	Data Element	271 Response AAA Segment	Expected Value	Detected Value
	<b><u>Invalid Provider PIN.</u></b>	<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>43: Invalid/Missing Provider Identification</u></b>
	<b><u>BATCH ONLY</u></b>	<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>
2100C	NM101 is not IL	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	15: Required application data missing
		AAA04	C: Please Correct and Resubmit	C
	NM102 <b><u>Is not 1</u></b>	AAA01	Y/N Response Code	N
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>15: Required application data missing</u></b>
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>
	NM108 is not MI	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	15: Required application data missing
		AAA04	C: Please Correct and Resubmit	C
	NM109 is not present	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	72: Invalid/Missing Subscriber/Insured ID
		AAA04	C: Please Correct and Resubmit	C
	NM109 <b><u>is present but not on file</u></b>	AAA01	Y/N Response Code	N
		AAA03	Reject Reason Code	75: Subscriber ID Not Found
		AAA04	C: Please Correct and Resubmit	C
	<b><u>DMG01 is not D8</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>15: Required application data missing</u></b>
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>
	<b><u>DMG02 is not a valid date</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>58: Invalid/Missing Date of Birth</u></b>
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>
	<b><u>DTP01 is not 102 or 472</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>15: Required application data missing</u></b>
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>
<b><u>DTP02 is not D8</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>	
	<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>15: Required application data missing</u></b>	
	<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>	
<b><u>DTP03 is not a valid Service date</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>	
	<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>57: Invalid Missing Date of Service</u></b>	
	<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>	

Loop Level	Data Element	271 Response AAA Segment	Expected Value	Detected Value	
	<b><u>DTP03</u></b> <b><u>is not a valid Issue date</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>	
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>56: Inappropriate Date (Issue Date)</u></b>	
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>		
	<b><u>BATCH ONLY</u></b> <b><u>System Not Available</u></b>	<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>Y</u></b>	
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>42: Unable to Respond at the Current Time</u></b>	
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>R</u></b>	
	2110C	AMT01 is not R or PB for Spend Down	AAA01	Y/N Response Code	N
			AAA03	Reject Reason Code	15: Required application data missing
			AAA04	C: Please Correct and Resubmit	C
AMT02 is not a dollar amount for Spend Down		AAA01	Y/N Response Code	N	
		AAA03	Reject Reason Code	15: Required Application Data Missing	
		AAA04	C: Please Correct and Resubmit	C	
<b><u>DTP03</u></b> <b><u>is not a valid issue date</u></b>		<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>	
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>56: Inappropriate Date (Issue Date)</u></b>	
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>		
<b><u>DTP03</u></b> <b><u>is valid but not within 13 months of the current month</u></b>		<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>	
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>62: Date of Service Not within allowable Inquiry Period</u></b>	
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>	
<b><u>DTP03</u></b> <b><u>is valid but is a date in the future</u></b>		<b><u>AAA01</u></b>	<b><u>Y/N Response Code</u></b>	<b><u>N</u></b>	
		<b><u>AAA03</u></b>	<b><u>Reject Reason Code</u></b>	<b><u>63: Date of Service in Future</u></b>	
		<b><u>AAA04</u></b>	<b><u>C: Please Correct and Resubmit</u></b>	<b><u>C</u></b>	