



**UnitedHealth Group<sup>SM</sup>**

**Standard Companion Guide**

**Refers to the Technical Report Type 3 (TR3)  
(Implementation Guide)**

**Based on X12N (Version 005010X220A1)**

**Companion Guide Version**

**[EDI - 834]**

**Benefit Enrollment and Maintenance**

**Version Number: 1.0**

**October 2010**

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## **Benefit Enrollment and Maintenance**

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### Change Log

Version	Release Date	Changes
1.0	2010-10-01	Initial External Release

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### **Preface**

This Companion Guide to the ASC X12N Technical Report Type 3 (TR3), also known as Implementation Guides (IGs), adopted under HIPAA, clarifies and specifies the data content when exchanging electronically with UnitedHealthcare. Transmissions based on this Companion Guide, used in tandem with the X12N Implementation Guides, are compliant with both X12N syntax and those Guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

This transaction set can be used by employers, unions, government agencies, associations, or insurance agencies to enroll members to a payer. The payer is a healthcare organization that pays claims, administers insurance or benefit or product. Examples of payers include an insurance company, health care professional (HMO), preferred provider organization (PPO), government agency (Medicaid, Medicare etc.) or any organization that may be contracted by one of these former groups.

Improvements have been made to the **5010 834** layout that include updates throughout the X12N Implementation Guide with semantic notes that more clearly define the transaction.

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## 1. INTRODUCTION

This section describes how X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The table contains a row for each segment that UnitedHealthcare has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare

In addition to the row for each segment, one or more additional rows are used to describe UnitedHealthcare's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides. The table contains a row for each segment that UnitedHealthcare has something additional, over and above, the information in the IGs. Following is just an example of the type of information that would be spelled out or elaborated on in: Section 9 – Transaction Specific Information (see below).

Page	Loop Id	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Acme Health Plan.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

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## 1.1. SCOPE

The purpose of this document is to provide the information necessary to submit **5010 834** Benefit Enrollment and Maintenance transactions electronically to/from UnitedHealthcare. This Companion Guide is to be used in conjunction with the ANSI X12N Implementation Guides. The Companion Guide supplements, but does not contradict or replace any requirements in the Implementation Guide. The Companion Guide specifications define current functions and other information specific to UnitedHealthcare in processing electronic eligibility via the **5010 834** transaction.

## 1.2. OVERVIEW

This Companion Guide will replace, in total, the previous UnitedHealthcare Companion Guide for **5010 834** Benefit Enrollment and Maintenance, including the latest release dated February 2007 and all previous releases.

This UnitedHealthcare **5010 834** Benefit Enrollment and Maintenance Companion Guide has been written to assist you in designing and implementing **5010 834** Benefit Enrollment transactions to meet UnitedHealthcare's processing standards. This Companion Guide must be used in conjunction with the **5010 834** Benefit Enrollment and Maintenance instructions as set forth by the ASC X12N Standards for Electronic Data Interchange Addenda A1 (Version **005010X220A1**), June 2010 (referred to hereafter as the Implementation Guide or IG). The UnitedHealthcare Companion Guide identifies key data elements from the transaction set that we request you provide to us and response we will return. The recommendations made are to enable you to more effectively complete EDI transactions with UnitedHealthcare.

Updates to this Companion Guide will occur periodically and new documents will be posted on [www.UnitedHealthcareOnline.com](http://www.UnitedHealthcareOnline.com) > News. These updates will also be available at [http://www.uniprise.com/hipaa/Companion\\_docs.html](http://www.uniprise.com/hipaa/Companion_docs.html) and distributed to all registered trading partners with reasonable notice, or a minimum of 30 days, prior to required Implementation.

In addition,

- Trading partners can sign up for email alerts on [www.UnitedHealthcareOnline.com](http://www.UnitedHealthcareOnline.com) > News > Register to receive important news and updates including the Network Bulletin. Information will be included in these alerts anytime an updated **5010 834** document is posted online.

## 1.3. REFERENCE

For more information regarding the ASC X12N Standards for Electronic Data Interchange (Version **005010X220A1**) **5010 834** Benefit Enrollment and Maintenance and to purchase copies of these documents, consult the Washington Publishing Company web site at: [www.wpc-edi.com](http://www.wpc-edi.com)

## 1.4. ADDITIONAL INFORMATION

### Assumptions

- For more information on whether an employer group or Third-Party Administrator acting on behalf of the employer group needs to submit enrollment data in compliance with the **5010 834** transaction standard, please consult counsel or refer to the U.S. Department of Health and Human Services website at: <http://aspe.os.dhhs.gov/admsimp/pl104191.htm#261>
- **5010 834** Health Care Benefit Enrollment and Maintenance transactions submitted to UnitedHealthcare are assumed to be production-ready. Although the **834** file may be compliant in format, UnitedHealthcare specific data will still need to be tested, so any files submitted to UnitedHealthcare will not be considered production ready until Implementation is complete (e.g., Plan data submitted in HD04, Customer and Policy specific data submitted in the REF segments in Loop 2000 and 2300, etc.). The employer groups, Third-Party Administrators, and system vendor(s) will have completed testing prior to submission to ensure HIPAA compliance.

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## **Benefit Enrollment and Maintenance**

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### **2. GETTING STARTED**

#### **2.1. WORKING WITH UnitedHealthcare**

Below are general Guidelines that should be followed when working with UnitedHealthcare.

##### **General File Submission Requirements**

1. UnitedHealthcare strongly recommends that employer groups or Third-Party Administrators representing the employer group obtain certification from an approved Third-Party Certification System and Service (TPCSS), stipulating that its transactions are HIPAA compliant. For more information about certification and certification vendors, speak to the appropriate Electronic Eligibility Analyst at UnitedHealthcare.
2. While UnitedHealthcare supports all of the characters in the extended character set, it is recommended that incoming **5010 834** data use the basic character set as defined in Appendix B of the Implementation Guide.
3. Some of the segments and data elements labeled as “**Not Used**” in this Companion Guide, but labeled as “**Situational**” in the Implementation Guide, may still be accepted and validated to ensure HIPAA compliance. However, UnitedHealthcare will not actually process these segments and data elements.
4. Data submitted to UnitedHealthcare in ANSI HIPAA standard format may be translated into a proprietary format for purposes of internal processing.
5. Only multiple data loops or segments should be populated with the first occurrence, and each loop or segment populated consecutively thereafter. There should be no loops or segments without data.
6. UnitedHealthcare prefers to receive only one transaction type (records group) per interchange (transmission). A submitter should only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange), however, UnitedHealthcare does allow multiple ST/SEs within a transaction for multi-customer files to be submitted.
7. Trading Partners cannot send test and production information within the same transaction file, regardless of the transaction. Test data and production data must be submitted in separate files. Notify your Electronic Eligibility Analyst at UnitedHealthcare regarding submission of test data.
8. As of the release of this document (October 2010), UnitedHealthcare accepts the following versions of the Implementation Guide, and any future versions as specified by the regulation:
  - ANSI ASC X12N 834 (Version **005010X220A1**)

##### **Causes for Rejection of File Submission**

1. Delimiters must be consistently applied throughout the transmissions. Any delimiter can be used as long as the same one is used throughout the transaction. Printable characters are preferred. A carriage return/linefeed **will** cause an interchange/transmission to be rejected.
2. Only loops, segments, and data elements valid for the Implementation Guide will be translated. Submission of data that is not valid based on the Implementation Guide will cause files to be rejected.
3. If a segment or data element within a segment is specified in the Implementation Guide as “**Not Used**,” yet is present in the transaction, it will be rejected as an error.
4. UnitedHealthcare will reject an interchange transmission that is not submitted with unique values in the **ST02** (Transaction Set Control Number) or **GS06** (Group Control Number) elements within the interchange transmission.

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### **Third-Party Administrators**

For employer groups' EDI enrollment requests, it is necessary to contact the Third-Party Administrators directly. They will provide all the necessary testing and submission information required.

### **Direct Submissions**

For direct submission to UnitedHealthcare or for details regarding communication protocols, contact the Electronic Eligibility Analyst at UnitedHealthcare who will then send the Employer or TPA an EDI transmission questionnaire and set up the connection.

### **Privacy and Security Protection**

UnitedHealthcare will comply with the privacy and confidentiality requirements as outlined in the HIPAA Privacy and Security regulations regarding the need to protect health information. All Trading Partners are also expected to comply with these regulations.

### **Encryption Requirements**

UnitedHealthcare will comply with the data encryption policy as outlined in the HIPAA Privacy and Security regulations regarding the need to encrypt health information and other confidential data. All data within a transaction that is included in the HIPAA definition of Electronic Protected Health Information (ePHI) will be subject to the HIPAA Privacy and Security regulations and UnitedHealthcare will adhere to such regulations and the associated encryption rules. All Trading Partners are also expected to comply with these regulations and encryption policies.

## **2.2. TRADING PARTNER REGISTRATION**

Please refer to your on-boarding process/protocol, which is available by contacting your Electronic Eligibility Analyst at UnitedHealthcare.

## **2.3. CERTIFICATION AND TESTING OVERVIEW**

All trading partners who wish to submit **5010 834** Benefit Enrollment and Maintenance transactions electronically to/from UnitedHealthcare via the ANSI ASC X12N 834 (Version **005010X220A1**) and receive corresponding EDI responses must complete testing to ensure that their systems and connectivity are working correctly before any production transactions can be processed.

### 2.4. TESTING WITH THE TRADING PARTNER

#### **Testing Requirements**

##### **EDI Trading Partner Testing**

UnitedHealthcare has adopted the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Testing Sub-Workgroups recommendations on the types of testing that need to occur in order to remain in line with the health care industry's testing recommendations. Initially, the types of testing that UnitedHealthcare strongly recommends for the **5010 834** Transaction Set includes:

**Type 1: EDI syntax integrity testing** – Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12N or NCPDP syntax, and compliance with X12N and NCPDP rules. This will validate the basic syntactical integrity of the EDI submission.

**Type 2: HIPAA syntactical requirement testing** – Testing for HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. Also included in this type is testing for HIPAA required or intra-segment situational data elements, testing for non-medical code sets as laid out in the Implementation Guide, and values and codes noted in the Implementation Guide via an X12N code list or table.

##### **Type 3: Other Testing Requirements**

- 1) We require live data for testing - not dummy data - whenever possible
- 2) A full file (All members) is required which includes ISA thru IEA control Segments
- 3) Eligibility scenarios should be tested - COBRA, Survivors, plan changes, Dependent Only coverage, termination processing, enrollments
- 4) Electronic transfer must be utilized to submit the file - we can not accept a test file via secure email since we use WTX for validation and translation

##### **Third-Party Certification Systems and Services (TPCSS)**

TPCSS vendors provide test data and testing services for anyone in need of testing compliance of their HIPAA transactions. UnitedHealthcare requests that Trading Partners test with a TPCSS and provide evidence of such testing. EDI submitters that have tested their **5010 834** Transaction Set with a certification system may provide a certificate of compliance. The certificate should specify the different types of testing passed or provide us with a certification website that indicates you have successfully passed certain types of certification testing.

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### **3. CONNECTIVITY WITH THE PAYER / COMMUNICATIONS**

#### **3.1. PROCESS FLOWS**

All trading partners who wish to submit 834 transactions to UnitedHealthcare must complete testing to ensure that their systems and connectivity are working correctly before any production transactions can be processed.

For issues or questions related to EDI Customer Service, please contact the [Electronic Eligibility Analyst] at UnitedHealthcare.

#### **3.2. TRANSMISSION ADMINISTRATIVE PROCEDURES**

The on-boarding process can be used in batch mode (FTP or SFTP). Using these types of connections, will allow you to either choose a manual process or automate your system.

#### **3.3. RE-TRANSMISSION PROCEDURE**

When a file needs to be retransmitted, the trading partner will contact the [Electronic Eligibility Analyst] at UnitedHealthcare. At that time, procedures will be followed for UnitedHealthcare to accept the retransmitted file.

#### **3.4. COMMUNICATION PROTOCOL SPECIFICATIONS**

The on-boarding process currently supports the following communications methods:

- FTP with PGP for Batch
- SFTP for Batch

#### **3.5. PASSWORDS**

Passwords for your communication protocol will be supplied upon completion of the communication set up. This information will be sent via secure email.

#### **3.6. SYSTEM AVAILABILITY & DOWNTIME**

UnitedHealthcare accepts **834** files 24 hours per day 7 days per week, however, UnitedHealthcare's normal business hours for **834 processing** are as follows:

Monday	thru	Friday	7:00 a.m.	thru	11:00 p.m.	EST
		Saturday	7:00 a.m.	thru	6:00 p.m.	EST
		Sunday	7:00 a.m.	thru	4:00 p.m.	EST

Outside these windows, UnitedHealthcare systems may be down for general maintenance and upgrades. During these times, our ability to process incoming **834** transactions may be impacted.

In addition, unplanned system outages may also occur occasionally and impact our ability to accept or immediately process incoming **834** transactions. We will send an email communication for scheduled and unplanned outages.

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### **4. CONTACT INFORMATION**

#### **4.1. EDI CUSTOMER SERVICE**

For issues or questions related to EDI Customer Service, please contact the Electronic Eligibility Analyst at UnitedHealthcare. Most questions can be answered by referencing the materials posted at [www.UnitedHealthcareOnline.com](http://www.UnitedHealthcareOnline.com) > News. Updates to the Companion Guide will also be posted at: [http://www.uniprise.com/hipaa/Companion\\_docs.html](http://www.uniprise.com/hipaa/Companion_docs.html)

#### **4.2. EDI TECHNICAL ASSISTANCE**

For issues or questions related to EDI Technical Assistance, please contact the Electronic Eligibility Analyst at UnitedHealthcare.

#### **4.3. PROVIDER SERVICE NUMBER**

For issues or questions related to **5010 834** Benefit Enrollment and Maintenance, please contact the following:

#### **4.4. APPLICABLE WEBSITES / E-MAIL**

For a copy of the **5010** Implementation Guide for **5010 834** Benefit Enrollment and Maintenance, please visit the following:

<b>Publication</b>	<b>Website(s)</b>
<b>Washington Publishing Company</b>	<b><u>Washington Publishing Company (Implementation Guides)</u></b>

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### 5. CONTROL SEGMENTS / ENVELOPES

Below is the current **5010 834** interchange that reviews the usage of all included elements according to the X12N Implementation Guide.

#### 5.1. ISA-IEA

Transactions transmitted during a session or as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

Communications transport protocol interchange control header segment. This segment within the X12N Implementation Guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header segment.

Page	Loop Id	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	<b>INTERCHANGE CONTROL HEADER</b>			
C.4		ISA01	Authorization Information Qualifier	00	ID – 2/2	00 = No authorization information present
C.4		ISA03	Security Information Qualifier	00	ID – 2/2	00 = No security information present
C.4		ISA05	Interchange ID Qualifier	ZZ	ID – 2/2	ZZ = Mutually Defined
C.4		ISA06	Interchange Sender ID	Direct to UHC = 87726	AN – 15/15	Interchange Sender ID. Left justify and pad with spaces to 15 characters.
C.5		ISA07	Interchange ID Qualifier	ZZ	ID – 2/2	ZZ = Mutually Defined
C.5		ISA08	Interchange Receiver ID	Direct to UHC = 87726	AN – 15/15	Receiver ID. Left justify and pad with spaces to 15 characters.
C.5		ISA11	Repetition Separator	*	Unknown 1/1	The delimiter in ISA11 must be an asterisk
C.6		ISA16	Component Element Separator	:	Unknown 1/1	The delimiter in ISA16 must be a colon

Communications transport protocol interchange control trailer segment. This segment within the X12N Implementation Guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

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### 5.2. GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope. The number of GS/GE functional groups that exist in the transmission.

Communications transport protocol functional group header segment. This segment within the X12N Implementation Guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

Page	Loop Id	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	<b>FUNCTIONAL GROUP HEADER</b>			
C.7		GS02	Application Sender's Code	Direct to UHC = 87726	AN - 2/15	
C.7		GS03	Application Receiver's Code	Direct to UHC = 87726	AN - 2/15	This is the same value as the Receiver's Interchange ID from ISA08 (do not pad with spaces).

Communications transport protocol functional group trailer segment. This segment within the X12N Implementation Guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

### 5.3. ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE).

Communications transport protocol transaction set header segment. This segment within the X12N Implementation Guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

Communications transport protocol transaction set trailer. This segment within the X12N Implementation Guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

## 6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

None have been identified at this time.

### 7. ACKNOWLEDGEMENTS AND OR REPORTS

#### 7.1. ACKNOWLEDGEMENTS

For every transaction received, there is an expected response. The available responses include:

- **[999]** – A Functional Acknowledgement

Once the transaction has passed the “front end” compliance check it then goes through a syntax compliance edit. This edit is to verify the compliance within the ANSI X12N syntax according to the HIPAA Implementation Guides. The transaction will receive a Functional Acknowledgement **[999]** to provide feedback on the transaction. The **[999]** functional acknowledgement contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred will be reported in a rejected acknowledgement. If the transaction contained no syntactical errors, a positive **[999]** response will be generated and the transaction is passed on for subsequent processing.

#### 7.2. REPORT INVENTORY

None have been identified at this time.

### 8. TRADING PARTNER AGREEMENTS

This section contains general information concerning Trading Partner (External Access) Agreements (TPA), which is available by contacting your [Electronic Eligibility Analyst] at UnitedHealthcare.

#### 8.1. TRADING PARTNERS

**Direct Connection** – The Trading Partner (External Access) Agreement must be signed and completed prior to set up.

### 9. TRANSACTION SPECIFIC INFORMATION

This section is reserved for any additional information, over and above the information contained in the IGs, that UnitedHealthcare requires in order to electronically submit **5010 834** Benefit Enrollment and Maintenance transactions.

### 10. APPENDECIES

#### 10.1. IMPLEMENTATION CHECKLIST

Your trading partners are the organizations with which you exchange transactions. The final step before going “live” with the **5010** transactions will be to complete testing with your trading partners. The testing will involve sending test transactions through the channels you use today, such as to the clearinghouses or payers. Sending test transactions is an opportunity to see if they will be received successfully, both by your trading partner’s system and your system. Be aware, however, that in some instances, testing will be done in live production environments with a subset of your transaction data.

Use the following steps to prepare for the Implementation of **5010**:

1. Talk to your current practice management system vendor.
2. Talk to your clearinghouses or billing service, if you use either one, and health insurance payers.
3. Identify changes to data reporting requirements.
4. Identify potential changes to existing practice work flow and business processes.
5. Identify staff training needs.
6. Test with your trading partners, (e.g., payers and clearinghouses).
7. Budget for Implementation costs, including expenses for system changes, resource materials, consultants, and training.

#### 10.2. BUSINESS SCENARIOS

Please refer to Section 4.4 above, which points to the appropriate Website where the reader can view the Implementation Guide, which contains various business scenario examples.

#### 10.3. TRANSMISSION EXAMPLES

Please refer to Section 4.4 above, which points to the appropriate Website where the reader can view the Implementation Guide, which contains various transmission examples.

#### 10.4. FREQUENTLY ASKED QUESTIONS

This appendix contains a compilation of questions and answers relative to UnitedHealthcare and its providers. Typical question would involve a discussion about code sets and their effective dates.

A Frequently Asked Questions document will be posted on [www.UnitedHealthcareOnline.com](http://www.UnitedHealthcareOnline.com) > News.

#### 10.5. CHANGE SUMMARY

For those business segments for which previous Companion Guide(s) do exist, the current Companion Guide refers to the 5010 Implementation of the transaction set, whereas the previous Companion Guide(s) refer to earlier HIPAA release standards such as [4010/4010A1].

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### 10.6. DEFINITIONS

Term	Qualifier	Definition
834		<b>834</b> – Inbound file containing <b>Benefit Enrollment and Maintenance</b> data
999		<b>999</b> – or Functional Acknowledgement for HIPAA 834 file. A functional acknowledgement will be sent by the receiver to the sender when an 834 file is received.
4010		<b>4010</b> – The October 1997 ASC X12N standard format, Version 4, Release 1, Sub-release 0 (00[4010])
4010A1		<b>4010A1</b> – The version of the transactions named in HIPAA is Version 004010 (4010) and its subsequent addenda, 004010A1 (4010A1), are collectively referred to as “4010A1.” These electronic transactions were developed by the standards development organization Accredited Standards Committee X12N (ASC X12N). Standards development organizations are bodies that develop standards used in various industries, such as banking standards that enable you to use your ATM card in any ATM.
5010		<b>5010</b> – The August 2006 ASC X12N standard format, Version 5, Release 1, Sub-release 0 (005010).
Acknowledgement		<b>Acknowledgement</b> – The Acknowledgement is the electronic response, or 999, or Functional Acknowledgement for HIPAA 834 file.
ANSI ASC X12N ASC X12N X12N		<b>ANSI ASC X12N</b> – is the official designation of the U.S. national standards body for the development and maintenance of Electronic Data Interchange (EDI) standards. EDI X12N (Electronic Data Interchange) is a data format based on ASC X12N standards. It is used to exchange specific data between two or more trading partners.
B2B		<b>B2B</b> – Business-to-business, or “B2B,” is a term commonly used to describe electronic commerce transactions between businesses, as opposed to those between businesses and other groups, such as business and individual consumers (B2C) or business and government (B2G).  <b>B2B</b> – is also commonly used as an adjective to describe any activity, be it marketing, sales, or ecommerce that occurs between businesses and other businesses rather than between businesses and consumers.
CAQH		<b>CAQH</b> – is an unprecedented nonprofit alliance of health plans and trade associations, and is a catalyst for industry collaboration on initiatives that simplify healthcare administration. CAQH solutions promote quality interactions between plans, providers, and other stakeholders; reduce costs and frustrations associated with healthcare administration; facilitate administrative healthcare information exchange and encourage administrative and clinical data integration.
Companion Guide		<b>Companion Guide</b> – A handbook that assists with giving information and instructions on the EDI 834 transactions.
CORE		<b>CORE</b> – Committee on Operating Rules for Information Exchange – a segment of CAQH whose mission is to promote interoperability of transactions among healthcare payers. <a href="http://www.caqh.org/CORE_overview.php">http://www.caqh.org/CORE_overview.php</a>
EDI		<b>EDI</b> – Electronic Data Interchange is the computer-to-computer exchange of business or other information between two organizations (trading partners). The data may be either in a standardized or proprietary format. Also known as electronic commerce.
EDI 834		<b>EDI 834</b> – The 834 EDI Transactions can be used by employers, unions, government agencies, associations or insurance agencies to enroll members to a payer. The payer is a healthcare organization that pays claims, administers insurance or benefit or product. Examples of payers include an insurance company, health care professional (HMO), preferred provider organization (PPO), government agency (Medicaid, Medicare etc.) on any organization that may be contracted by one of these former groups.

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## Benefit Enrollment and Maintenance

Term	Qualifier	Definition
<b>EDI X12N Standards and Releases</b>		<p><b><u>EDI X12N Standards and Releases</u></b> – EDI X12N is governed by standards released by ASC X12N (The Accredited Standards Committee). Each release contains set of message types like invoice, purchase order, healthcare claim, etc. Each message type has specific number assigned to it instead of name. For example: an invoice is 810, purchase order is 850 and healthcare claim is 837, Eligibility is 834. Every new release contains new version number. Version number examples: 4010, 4020, 4030, 5010, 5030, etc. Major releases start with new first number. For example: 4010 is one of the major releases, so is 5010. However 4020 is minor release. Minor releases contain minor changes or improvements over major releases. Understanding the difference between major and minor releases is important. Let say you have working translation for some messages for release 4010, and if you want to upgrade to 4020 you will notice only a few changes between the two, and if you want to upgrade to release 5010 you might need to make a lot of modifications to current translation. At the time of this writing 4010 is most widely used release. It is the first release that is Y2K compliant.</p> <p>Most of HIPAA based systems know and use 4010. Conclusion: to translate or validate EDI X12N data you need to know transaction number (message numeric name) and release version number. Both of those numbers are inside the file.</p>
<b>HIPAA</b>		<p><b><u>HIPAA</u></b> – Health Insurance Portability and Accountability Act of 1996 is a federal law intended to improve the availability and continuity of health insurance coverage that, among other things, places limits on exclusions for pre-existing medical conditions; permits certain individuals to enroll for available group health care coverage when they lose other health coverage or have a new dependent; prohibits discrimination in group enrollment based on health status; provides privacy standards relating to individuals' personally identifiable claim-related information; guarantees the availability of health coverage to small employers and the renewability of health insurance coverage in the small and large group markets; requires availability of non-group coverage for certain individuals whose group coverage is terminated; and establishes standards for electronic transmissions.</p>
<b>ICD-9</b>		<p><b><u>ICD-9</u></b> – ICD-9 is an acronym used in the medical field that stands for International Classification of Diseases, ninth revision. In the United States, the ICD-9 covered the years 1979 to 1998. Currently, ICD-10, which is the tenth revision, is in effect as the most current database of disease classifications. ICD-9 was used in the US until the 10th revision became fully implemented in 1998, though the actual revision was concluded some years earlier.</p>
<b>ICD-10</b>		<p><b><u>ICD-10</u></b> – The <b>International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)</b> is a coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO). The code set allows more than 155,000 different codes and permits tracking of many new diagnoses and procedures, a significant expansion on the 17,000 codes available in ICD-9.</p>
<b>Protocols</b>		<p><b><u>Protocols</u></b> – Protocols are codes of correct conduct for a given situation.</p>
<b>Qualifier</b>		<p><b><u>Qualifier</u></b> – A qualifier is a word, number, or characters that modifies or limits the meaning of another word or group of words or dates.</p>
<b>Segment</b>		<p><b><u>Segment</u></b> – a string of data elements that contain specific values based on the loop and data element on file which is separated into specific sections.</p>

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## Benefit Enrollment and Maintenance

Term	Qualifier	Definition
<b>Third Party Administrator (TPA)</b>		<b><u>Third party administrator</u></b> – TPA's are prominent players in the managed care industry and have the expertise and capability to administer all or a portion of the claims process. They are normally contracted by a health insurer or self-insuring companies to administer services, including claims administration, premium collection, no enrollment and other administrative activities. A hospital or provider organization desiring to set up its own health plan will often outsource certain responsibilities to a TPA.
<b>Trading Partner</b>		<b><u>Trading Partner</u></b> – A Trading Partner may represent an organization, group of organizations or some other entity. In most cases it is just an organization or company.
<b>Trading Partner Requirements</b>		<b><u>Trading Partner Requirements</u></b> – EDI X12N standard covers number of requirements for data structure, separators, control numbers, etc. However many big trading partners impose they own even more strict rules and requirements. It can be everything: specific data format requirements for some elements, requirement to contain specific segments (segments that are <u>not</u> mandatory in EDI X12N standard being made mandatory), etc. In HIPAA those specific trading partner requirements are usually listed in separate document called Companion Guide. It is essential to follow these documents to the letter when implementing EDI systems.

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