GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GAMMIS
GEORGIA MEDICAID MANAGEMENT INFORMATION SYSTEM

Georgia Department of Community Health (DCH)

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3)
Implementation Guide
Based on ASC X12N version: 005010X220A1

Inbound/Outbound Benefit Enrollment and Maintenance (834)

February 2015 005010 Version: 2.4

Disclosure Statement

The following Georgia Department of Community Health (DCH) Companion Guide is intended to serve as a companion guide to the corresponding ASC X12N/005010X220 Benefit Enrollment and Maintenance (834), its related Addenda (005010X220A1) and its related Errata (005010X220E1). The companion guide further specifies the requirements to be used when preparing, submitting, receiving and processing electronic health care administrative data. This companion guide supplements, but does not contradict, disagree, oppose, or otherwise modify the 005010X220 in a manner that will make its implementation by users to be out of compliance.

Note:

Type 1 TR3 Errata are substantive modifications, necessary to correct impediments to implementation, and identified with a letter 'A' in the errata document identifier. Type 1 TR3 Errata were formerly known as Implementation Guide Addenda.

Type 2 TR3 Errata are typographical modifications, and identified with a letter 'E' in the errata document identifier.

The information contained in this Companion Guide is subject to change. Electronic Data Interchange (EDI) submitters are advised to check the Georgia Web Portal site http://www.mmis.georgia.gov regularly for the latest updates.

About DCH

Through effective planning, purchasing and oversight, the Georgia Department of Community Health (DCH) provides access to affordable, quality health care to millions of Georgians, including some of the state's most vulnerable and underserved populations.

DCH is responsible for Medicaid and PeachCare for Kids®, the State Health Benefit Plan, Healthcare Facility Regulation and Health Information Technology in Georgia. http://dch.georgia.gov/

Mission Statement

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to ***A Healthy Georgia.***

Preface

This Companion Guide to the 5010 ASC X12N Technical Report Type 3 Implementation Guides and associated errata and addenda adopted under HIPAA clarifies and specifies the data content when exchanging electronically with DCH. Transmissions based on this companion guide, used in tandem with 005010 ASC X12 TR3 Implementation Guide, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N TR3 Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that is any way exceeds the requirements or usages of data expressed in the TR3 Implementation Guides.

Table of Contents

1 Introduction

This section describes how TR3 Implementation Guides, also called 834 ASC X12N (version 005010X220A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Georgia Medicaid has information additional to the TR3 Implementation Guide. 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 implementation guide's internal code listings.
4. Clarify the use of loops, segments, composite and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Georgia Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe Georgia Medicaid'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 Notes/Comments column to provide additional information from Georgia Medicaid for specific segments provided by the TR3 Implementation Guide. The following is just an example of the type of information that would be spelled out or elaborated on in the Section 11: Transaction Specific Information.

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 percent and notes or comments about the segment itself go in this cell.
193	2100C	NM109	Subscriber Primary Identifier	00	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 Georgia Medicaid Management Information System (GAMMIS).

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			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 three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
241	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.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 834 Implementation Guide for the purpose of submitting and receiving benefit enrollment and maintenance transactions electronically. This companion guide is not intended to replace the TR3 Implementation Guide. The TR3s define the national data standards, electronic format, and values for each data element with an electronic transaction. The purpose of this companion guide is to provide trading partners with a companion guide to communicate Georgia Medicaid-specific information required to successfully exchange transactions electronically with Georgia Medicaid. The instructions in this companion guide are not intended to be stand-alone requirements. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

Georgia Medicaid will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Georgia Medicaid-specific information, though processed through EDI, may be rejected by backend processes.

Refer to this companion guide first if there is a question about how Georgia Medicaid processes a HIPAA transaction. For further information, contact the HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590. This companion guide is intended as a resource to assist providers, clearinghouses, service bureaus, and all other trading partners with Georgia Medicaid interChange in successfully conducting EDI of administrative health care transactions. This companion guide provides instructions for enrolling as a Georgia Medicaid trading partner, obtaining technical assistance,

initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This companion guide does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

Per HIPAA requirements, Georgia Medicaid and all other covered entities must comply with the EDI standards for health care as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required under HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. Additionally, HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The HIPAA requirements serve to:

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

This companion guide is designed to help those responsible for testing and setting up inbound and outbound electronic benefit enrollment and maintenance transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to Georgia Medicaid. This companion guide supplements (but does not contradict) requirements in the ASC X12N 834 (version 005010X220A1) implementation guide. This information should be given to the provider's business area to ensure that benefit enrollment and maintenance transactions are interpreted correctly.

This companion guide provides communications-related information a trading partner needs to enroll as a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Georgia Medicaid.

This companion guide must be used in conjunction with the TR3 Implementation Guide instructions. The companion guide is intended to assist trading partners in implementing inbound and outbound electronic 834 transactions that meet Georgia Medicaid processing standards by identifying pertinent structural and data-related requirements and recommendations. Updates to this companion guide will occur periodically and new companion guides will be posted on the GAMMIS Web Portal EDI >> Companion Guides page.

1.3 References

The TR3 Implementation Guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The TR3 Implementation Guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that your IT staff, or software vendor, review this companion guide in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Georgia Medicaid.

The TR3 Implementation Guides for X12N and all other HIPAA standard transactions are available electronically at http://www.wpc-edi.com/.

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X 12 standard is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers.

The intended audience for this companion guide is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific identification numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that should be submitted on these transactions from a health care provider.

For all non-healthcare providers where an NPI is not assigned, the Medicaid provider number should be submitted.

Acceptable Characters

For real-time, the HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. For batch, the HIPAA transactions can contain carriage returns and line feeds, however it is recommended that the data is received in one, continuous stream without carriage return and line feeds. Georgia Medicaid accepts the extended character set. Uppercase characters are recommended.

For outbound HIPAA transactions the data will be sent in one, continuous stream without carriage return and line feeds.

Acknowledgements

An accepted 999 Implementation Acknowledgement, rejected 999 Implementation Acknowledgement, or rejected TA1 InterChange Acknowledgement will be generated in response to all inbound batch submitted files.

Trading partners are responsible for retrieving acknowledgments to determine the status of

their files.

2 Getting Started

2.1 Working with Georgia Medicaid

This section describes how to interact with HP Enterprise Services' EDI Department.

Georgia Medicaid trading partners should exchange electronic health care transactions with HP Enterprise Services via the GAMMIS Web Portal, Remote Access Server (RAS), Secure File Transfer Protocol (SFTP), Network Routing Module Service (NRM), and Healthcare Transaction Services (HTS) or through a Georgia Medicaid approved Value Added Network (VAN).

After establishing a transmission method, each trading partner must successfully complete testing. Additional information is provided in the next section of this companion guide. After successful completion of testing, production transactions may be exchanged.

2.2 Trading Partner Registration

This section describes how to register as a trading partner with HP Enterprise Services.

All trading partners are required to complete the Georgia Medicaid trading partner agreement (TPA) form to enroll into EDI Services. Those trading partners that are using an already enrolled billing agent, clearinghouse, or software vendor do not need to enroll separately since they are already enrolled to transmit electronically. Only one trading partner ID is assigned per submitter location. If multiple trading partner IDs are needed for the same address location, please attach a letter to the TPA explaining the need for the additional trading partner ID. Providers must use the secure GAMMIS Web Portal to delegate access to their clearinghouse, billing agent, or software vendor to allow EDI files to be downloaded on their behalf. Information on how to delegate access is found in the Web Portal User Account Management Guide on the GAMMIS Web Portal Provider Information >> Provider Manuals page.

If you are already enrolled to transmit or receive electronically and would like to make a change to your EDI trading partner ID profile or provider ID (ERA Only) profile, please complete the HP EDI Submitter Update Form found on the GAMMIS Web Portal page EDI >> Registration Forms indicating the changes you wish to make. The following changes can be made: Trading Partner Name, Contact Information, Address, Status (Active or Inactive), Transmission Method, and Transaction Types. Trading partners cannot change their trading partner ID. This ID can simply be deactivated using the EDI Submitter Update Form and a new EDI TPA for enrollment must be submitted once the original trading partner ID has been deactivated.

Trading Partners that will be exchanging electronic health care transactions SFTP are required to complete the SFTP Setup Request Form found on the GAMMIS Web Portal page EDI >> Registration Forms. This form must be signed by an authorized agent and is necessary to transmit to and from the GAMMIS server. Failure to submit this form will cause your enrollment to be delayed, and/or

returned to you as incomplete. For more information on SFTP access, please review the SFTP Setup and Data Transfer Requirements manual on the EDI >> Software and Manuals page.

If you have already completed these forms, you will not be required to complete them again. Please contact the HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590 if you have any questions about these forms.

2.3 Certification and Testing Overview

All trading partners will be certified through the completion of trading partner testing.

All trading partners that exchange electronic transactions with Georgia Medicaid must complete trading partner testing. This includes billing agents, clearinghouses or software vendors. Failure to do so will prevent successful transmissions of electronic files to the GAMMIS. Testing is not required if using the Provider Electronic Solutions (PES) software.

Providers who use a billing agent, clearinghouse or software vendor will not need to test for those electronic transactions that their entity submits on their behalf.

3 Testing with Georgia Medicaid

Before exchanging production transactions with GAMMIS, each trading partner must complete testing. All trading partners who plan to exchange transactions must contact HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590 in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

For batch inbound transactions that do not have an associated response (e.g., 837, 834) testing is done through Ramp Manager which is a free interactive X12 testing website, configured to test GAMMIS X12N inbound transactions against the TR3 Implementation Guides and Georgia specific processing rules. To access Ramp Manager, visit the Georgia Health Partnership Ramp Management System Web site at: https://sites.edifecs.com/index.jsp?gamedicaid. A set of instructions for using the Ramp Manager site and its tools are available in the Ramp Manager User Guide, located on the EDI >> Software and Manuals page.

You will be required to have a test file that has passed compliance for each type of transaction you will be sending. The status of each transaction should show “Passed” in Ramp Manager to show that you have successfully passed compliance before HP Enterprise Services can make you an active trading partner.

For batch and real-time transactions that do have an associated response (e.g., 270/271, 276/277) HP Enterprise Services will process these transactions in a test environment to verify that the file structure and content meet HIPAA standards and Georgia Medicaid-specific data requirements and provide the associated response transaction. Once this validation is complete, the trading partner may submit production transactions to HP Enterprise Services for processing.

HP Enterprise Services does not require a specific number of test files to be sent however your test file(s) should contain as many as possible to cover each of your business scenarios.

4 Connectivity with Georgia Medicaid / Communications

This section describes the process to submit or receive HIPAA 834 transactions, along with various submission methods, security requirements, and exception handling procedures.

Georgia Medicaid supports multiple methods for exchanging electronic healthcare transactions:

- GAMMIS Web Portal
- Remote Access Server (RAS) (PES Users Only)
- Secure File Transfer Protocol (SFTP) (Batch Only)
- Network Routing Module Service (NRM) (Real-Time Only)
- Georgia Medicaid approved Value Added Network (VAN)
- Healthcare Transaction Services (HTS) (Batch or Real-Time)

4.1 Process Flows

This section contains process flow and appropriate text.

Inbound Benefit Enrollment and Maintenance
The response to an inbound 834 batch transaction will consist of the following:

1. First level response: TA1 will be generated when errors occur within the outer envelope (no 999 will be generated).
2. Second level response: 999 will be generated. “Rejected” 999 when errors occur during 834 compliance validation or “Accepted” 999 if no errors are detected during the compliance validation.
3. Third level response for Managed Care Only: If the incoming 834 was for Reconciliation, once the transaction is “Accepted” the transaction is translated and sent to the backend for processing. Once the backend receives and runs the reconciliation process an outgoing 834 transaction is generated and sent to the CMO.

Each transaction is validated to ensure that the 834 complies with the 005010X220A1 TR3 Implementation Guides.

Inbound transactions that fail this compliance check will generate a “Rejected” 999 file back to the sender with AK9*R to indicate that the file failed compliance. Transactions that pass this compliance check will generate an “Accepted” 999 file back to the sender with AK9*A to indicate that the file passed compliance. For 834 files that contain multiple transactions (ST/SE) and one or more of those transactions fail this compliance check the entire file will be “Rejected” back to the sender with AK5*R for those transactions that failed compliance, AK5*A for those that passed compliance, and AK9*R reflecting the entire file is being rejected. The submitter will need to correct those transactions that failed compliance and resubmit the entire file for processing.

4.2 Transmission Administrative Procedures

This section provides Georgia Medicaid's specific transmission administrative procedures. Determine if the transmission you are sending is Test or Production and is using the appropriate indicator. For details about available Georgia Medicaid Access Methods, refer to the Communication Protocol Specifications section below.

Georgia Medicaid is available only to authorized users. Submitters must be Georgia Medicaid trading partners. A submitter is authenticated using a Username and Password assigned by the trading partner.

System Availability

The system is typically available 24x7 with the exception of scheduled maintenance windows which are posted on the GAMMIS Web Portal at https://www.georgia.gov. Non-Routine and emergency downtime will also be posted on the GAMMIS Web Portal. The system is available on all holidays.

Transmission Errors

When processing an 834 EDI transaction that has Interchange Header errors a TA1 will be generated. If the Interchange Header is valid, but the transaction fails compliance a 999 will be generated.

Managed Care Inbound/Outbound File Naming Convention and Requirements

- Georgia Medicaid will only accept Windows/PC/DOS formatted files. Any file transmitted to GAMMIS must be named in accordance to standard file naming conventions.
- Only one X12 transaction file is permitted in each zipped file.
- SFTP submitters:

  During the SFTP transmission all files should be named with a temporary extension "tmp" or "temp" until they are fully uploaded, and then renamed to the final filename.

  Example:
  - During upload: 834qi_cmo_us_20110417_235959_001.txt.pgp.tmp
  - After upload rename to: 834qi_cmo_us_20110417_235959_001.txt.pgp

  These "tmp" filename extensions tell the SFTP server the transmission is in process. Once the "tmp" is removed from the name, the SFTP server will assume the transmission is complete, and processing of the file can be performed.

There are 4 types of 834 files for Managed Care:

1. 834 daily (inbound / outbound).
2. 834 roster (outbound) run on the 24th of each month – CMO and EB only.
3. 834 variance (outbound) run on the last day of the month – CMO and EB only. This will only show terminations since the roster was produced. For all other plans, this will be a real roster.

4. 834 reconciliation (inbound / outbound) run quarterly. Expected massive input from CMO and EB. Large output files sent in response.

There are 3 types of 834 Inbound files for Member:

1. 834 daily (DailyDCH834_xxx_yymmddhhmmss.txt)
2. 834 monthly (MonthlyDCH834_xxx_yymmddhhmmss.txt).
3. 834 quarterly (QuarterlyDCH834_xxx_yymmddhhmmss.txt).

where
- xxx is the file creation sequence number.
- yymmddhhmmss is the file creation date and time.

File Naming Convention for Inbound 834:

CMO (GF, MCHB and FCCMO):

- 834di_cmo_VV_YYYYMMDD_HHMMSS_SSS.dat.zip – daily inbound
- 834qi_cmo_VV_YYYYMMDD_HHMMSS_SSS.dat.zip – quarterly reconciliation inbound (GF only)
- 834qi_mchb_W_YYYYMMDD_HHMMSS_SSS.dat.zip – quarterly reconciliation inbound (MCHB only)

where
- VV is the vendor code “ag”, “ps”, “wc” or “af”.
- SSS is the sequence, starting at “001” for each vendor.

Note: Sequence increments occur at each 100,000 member records within a vendor’s batch. No file should contain more than 100,000 member records. YYYYMMDD_HHMMSS must remain the same for all files within a batch, only incrementing the sequence number.
- If one file out of the batch is corrupted, then an entire new batch submission is required where YYYYMMDD_HHMMSS should remain the same for all files within a batch, only incrementing the sequence number.
- Each input file will be within a zip file.

EB (GF and MCHB):

- 834di_cmo_eb_YYYYMMDD_HHMMSS_00_000.dat.zip – daily inbound
- 834qi_cmo_eb_YYYYMMDD_HHMMSS_SSS.dat.zip – quarterly reconciliation inbound (GF only)
- 834qi_mchb_eb_YYYYMMDD_HHMMSS_SSS.dat.zip – quarterly reconciliation inbound (MCHB only)

where

- SSS is the sequence, starting at "001".

Note: Sequence increments occur at each 100,000 member records within a batch. No file should contain more than 100,000 member records. YYYYMMDD_HHMMSS must remain the same for all files within a batch, only incrementing the sequence number.

- If one file out of the batch is corrupted, then an entire new batch submission is required where YYYYMMDD_HHMMSS should remain the same for all files within a batch, only incrementing the sequence number.
- Each input file will be within a zip file.

PSI/PCK (PeachCare / P4HB):

- Daily, Monthly and Quarterly PeachCare 834 Inbound
  - EDSDailyDCH834_VVV_YYYYMMDD_HHMMSS.zip
  - EDSMonthlyDCH834_VVV_YYYYMMDD_HHMMSS.zip
  - EDSQuarterlyDCH834_VVV_YYYYMMDD_HHMMSS.zip

- Daily and Quarterly P4HB 834 Inbound
  - HPDailyP4HB834_999_ VVV_YYYYMMDD_HHMMSS.zip
  - HPQuarterlyP4HB834_ VVV_YYYYMMDD_HHMMSS.zip

- Each input file will be within a zip file.

File Naming Convention for Outbound 834:

CMO (GF, MCHB and FCCMO):

- 834do_cmo_VV_YYYYMMDD_HHMMSS_RR_SSS.dat.zip – daily outbound
- 834ro_cmo_VV_YYYYMMDD_HHMMSS_RR_SSS.dat.zip – roster outbound (24th of the month)
- 834vo_cmo_VV_YYYYMMDD_HHMMSS_RR_SSS.dat.zip – variance outbound (last day of month)
- 834ao_cmo_VV_YYYYMMDD_HHMMSS_RR_SSS.dat.zip – audit outbound (last day of month)
- 834qo_cmo_VV_YYYYMMDD_HHMMSS_SSS.dat.zip – quarterly reconciliation outbound (GF only)
- 834qo_mchb_W_YYYYMMDD_HHMMSS_SSS.dat.zip – quarterly reconciliation outbound (MCHB only)

where

- VV is the vendor code "ag", "ps", "wc" or "af".

- RR is the region code “01”, “02”, “03”, “04”, “05”, “06”.
- SSS is the sequence, starting at “001” for each vendor and region.
- RR_SSS = “00_000” is used for the daily errors from inbound records failing edits.

Note: Sequence increments occur at each 100,000 member records within a vendor.

- Each output file will be within a zip file.

EB (GF, MCHB and FCCMO):

- 834do_cmo_eb_YYYYMMDD_HHMMSS_00_000.dat.zip – daily outbound
- 834ro_cmo_eb_YYYYMMDD_HHMMSS_RR_SSS.dat.zip – roster outbound (24th of the month)
- 834vo_cmo_eb_YYYYMMDD_HHMMSS_00_000.dat.zip – variance outbound (last day of month)
- 834ao_cmo_eb_YYYYMMDD_HHMMSS_00_000.dat.zip – audit outbound (last day of month)
- 834qo_cmo_eb_YYYYMMDD_HHMMSS_SSS.dat.zip – quarterly reconciliation outbound (GF only)
- 834qo_mchb_W_YYYYMMDD_HHMMSS_SSS.dat.zip – quarterly reconciliation outbound (MCHB only)

where

- RR is the region code “01”, “02”, “03”, “04”, “05”, “06”.
- SSS is the sequence, starting at “001”.
- RR_SSS = “00_000” is used for the daily and variance files.

Note: Sequence increments occur at each 100,000 member records within a region for roster (24th) only. The daily and variance files are not split, and will include the inbound error records.

- Each output file will be within a zip file.

4.3 Retransmission Procedure

There is a situation where specific information is needed if a transaction needs to be retransmitted. Please reference information documented above within File Naming Convention information.

4.4 Communication Protocol Specifications

This section describes Georgia Medicaid’s communication protocol(s) for HIPAA 834 transactions.

Secure File Transfer Protocol (SFTP)

SFTP uses Secure Shell (SSH) to encrypt and then securely transmit data across a potentially unsecured connection. Functionally SFTP (required) is similar to FTP, but offers protection to sensitive data. SSH is a network protocol that allows data to be exchanged using a secure

channel between two networked devices.

Georgia Medicaid requires that the SFTP submitters send their public key and HP Enterprise Services exchanges its public key with the submitter for encryption purposes. HP Enterprise Services will setup a username and password for the submitter to access the server.

For more information on SFTP access, please review the SFTP Setup and Data Transfer Requirements manual on the EDI >> Software and Manuals page.

4.5 Passwords

Providers must adhere to the GAMMIS use of passwords. Providers are responsible for managing their own data. Each provider is responsible for managing access to their organization's data through the MMIS security function. Each provider must take all necessary precautions to ensure that they are safeguarding their information and sharing their data (e.g., Granting access) only with users and entities who meet the required privacy standards. It is equally important that providers know who on their staff is linked to other providers or entities, in order to notify those entities whenever they remove access for that person in your organizations.

For more information regarding passwords and use of passwords, contact the HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590.

5 Contact Information

Refer to this companion guide with questions, and then use the contact information below for questions not answered by this companion guide.

5.1 EDI Customer Service

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

Most questions can be answered by referencing the materials posted on the GAMMIS Web Portal at https://www.mmis.georgia.gov. If you have questions related to Georgia Medicaid's Benefit Enrollment and Maintenance (834), contact the HP Enterprise Services EDI Team at 1-877-261-8785 or 1-770-325-9590.

5.2 EDI Technical Assistance

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

HP Enterprise Services EDI Services Team can help with connectivity issues or transaction formatting issues at 1-877-261-8785 or 1-770-325-9590 Monday through Friday 8:00 a.m. to 5:00 p.m. EST. with the exception of holidays or via e-mail using the Contact Us link on the GAMMIS Web Portal.

Trading Partner ID: The Trading Partner ID is the GAMMIS key to accessing trading partner information. Trading partners should have this number available each time they contact the HP Enterprise Services EDI Services Team.

5.3 Provider Contact Center

This section contains detailed information concerning Provider Contact Center, especially contact numbers.

The Provider Contact Center should be contacted instead of the HP Enterprise Services EDI Services Team for questions regarding the details of a member's benefits, claim status information, credentialing and many other services. Provider Contact Center is available at 1-800-766-4456 or 1-770-325-9600 Monday through Friday 7:00 a.m. to 7:00 p.m. EST. with the exception of holidays or via e-mail using the Contact Us link on the GAMMIS Web Portal.

Note: Have the applicable provider identifier, the NPI for health care providers or the Medicaid provider ID for atypical providers available for tracking and faster issue resolution.

The Provider Relations representative, also known as field representatives, conduct training sessions on various Georgia Medicaid topics for both large and small groups or providers and billers. In addition to provider education, field representatives are available to assist providers with complex billing and claims processing questions. To find or contact the appropriate Provider Relations Representative, use the Contact Us link on the GAMMIS Web Portal.

5.4 Applicable Websites

This section contains detailed information about useful Web sites.

From GAMMIS secure Portal at https://www.mmis.georgia.gov non-enrolled providers can begin the enrollment process and enrolled providers can do all of the following:

- Create Dental, Institutional, and Professional claims for submission to GAMMIS.
- Check claim status and member enrollment.
- Submit authorizations, notifications, and referrals.
- View, download, and print explanation of benefits (EOBs), and Remittance Advices.

Trading Partners can do the following:

- Create Trading Partner Profile and complete authorization testing.
- Submit batch transactions (270, 276, 834, 837D, 837I and 837P).
- Download batch transactions/acknowledgements (271, 277, 277U, TA1, 824, 834, 999, 820 and 835).
- View, download and print companion guides.

A suite of other EDI and provider tools are also available on the GAMMIS Web Portal.

Additional information is available on the following Web sites:

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

Accredited Standards Committee (ASC X12N)

- ASC X12N develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes. www.x12.org

American Dental Association (ADA)

- Develops and maintains a standardized data set for use by dental organizations to transmit claims and encounter information. www.ada.org

American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classifications of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level 1 HCPCS. www.ahacentraloffice.org

American Hospital Association Central Office on ICD-10-CM/ICD-10-PCS (AHA)

- This site is a resource for the International Classifications of Diseases, 10th edition, Clinical Modification (ICD-10-CM) codes, used for reporting patient diagnoses and (ICD-10-PCS) for reporting hospital inpatient procedures. www.ahacentraloffice.org

American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Centers for Medicare & Medicaid Services (CMS)

- CMS is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-Care Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/HIPAAGenInfo/
- This site is the resource for information related to the Health-Care Common Procedure Coding System (HCPCS). www.cms.hhs.gov/HCPCSReleaseCodeSets/
- This site is the resource for Medicaid HIPAA informational related to the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim

Committee on Operating Rules for Information Exchange (CORE)

- A multi-phase initiative of CAQH, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care. www.caqh.org/CORE_overview.php

Council for Affordable Quality Healthcare (CAQH)

- A nonprofit alliance of health plans and trade associations, working to simplify healthcare administration through industry collaboration on public-private initiatives. Through two initiatives – the Committee on Operating Rules for Information Exchange (CORE) and Universal Provider Datasource (UPD), CAQH aims to reduce administrative burden for providers and health plans. www.caqh.org

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard-setting organizations and transaction change request system. www.hipaa-dsmo.org www.caqh.org

Georgia Department of Community Health (DCH)

- This DCH Web site assists providers with HIPAA billing and policy questions, as well as enrollment support. www.mmis.georgia.gov

Health Level Seven (HL7)

- HL7 is one of several ANSI-accredited Standards Development Organizations (SDOs), and is responsible for clinical and administrative data standards. www.hl7.org

Healthcare Information and Management Systems (HIMSS)

- An organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of health care. www.himss.org

Medicaid HIPAA Compliant Concept Model (MHCCM)

- This site presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit. www.mhccm.org

National Committee on Vital and Health Statistics (NCVHS)

- The National Committee on Vital and Health Statistics was established by Congress to serve as an advisory body to the Department of Health and Human Services on health data, statistics and national health information policy. www.ncvhs.hhs.gov

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association (AHA). It develops and maintains a national uniform billing instrument for use by the institutional health-care community to transmit claims and encounter information. www.nubc.org

National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association (AMA). It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

- OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (HHS)

- The DHHS Web site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction technical report type 3 implementation guides and code sets. www.wpc-edi.com

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org

6 Control Segments/Envelopes

6.1 ISA-IEA

This section describes Georgia Medicaid's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

To promote efficient, accurate electronic transaction processing, please note the following GAMMIS specifications:

- Each trading partner is assigned a unique trading partner ID.
- All dates are in the CCYYMMDD format with the exception of the ISA09 which is YYMMDD.
- All date/times are in the CCYYMMDDHHMM format.
- GAMMIS Trading Partner ID is 77034. This value must be sent within the ISA08 for inbound transactions and will be sent within the ISA06 for outbound transactions.
- Only one (1) ISA/IEA is allowed per logical file.

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

834 (Inbound/Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information	00	2	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Qualifier			
C.4		ISA02	Authorization Information		10	Space fill
C.4		ISA03	Security Information Qualifier	00	2	
C.4		ISA04	Security Information		10	Space fill
C.4		ISA05	InterChange ID Qualifier	ZZ	2	
C.4		ISA06	InterChange Sender ID		15	Inbound GF / MCHB / FCCMO: 'Enterprise ID' Supplied by Georgia Medicaid left justified and space filled. Inbound PCK / P4HB: 'Trading Partner ID' Supplied by Georgia Medicaid left justified and space filled. Outbound: Value = '77034' - GAMMIS Trading Partner ID, left justified and space filled.
C.4		ISA07	InterChange ID Qualifier	ZZ	2	
C.4		ISA08	InterChange Receiver ID		15	Inbound: Value = '77034' - GAMMIS Trading Partner ID, left justified and space filled. Outbound GF / MCHB / FCCMO: 'Enterprise ID' Supplied by Georgia Medicaid left justified and space filled.
C.5		ISA09	InterChange Date		6	Format is YYMMDD
C.5		ISA10	InterChange Time		4	Format is HHMM
C.5		ISA11	Repetition Separator	^	1	The repetition separator is a delimiter and not a data element. It is used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						from the data element separator, component element separator, and the segment terminator.
C.5		ISA12	InterChange Control Version Number	00501	5	
C.5		ISA13	InterChange Control Number		9	Must be identical to the associated interchange control trailer IEA01.
C.6		ISA14	Acknowledgment Requested	0, 1		
			No interchange acknowledgment requested	0	1	Inbound / Outbound
			Interchange acknowledgement requested	1	1	Inbound
C.6		ISA15	Usage Indicator	T, P		
			Test data	T	1	
			Production data	P	1	
C.6		ISA16	Component Element Separator	:	1	The component element separator is a delimiter and not a data element. It is used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups		1/5	Number of included Functional Groups.
C.10		IEA02	Interchange Control Number		9	The control number assigned by the interchange sender. Must be identical to the value in ISA13.

6.2 GS-GE

This section describes Georgia Medicaid's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how GAMMIS expects functional groups to be sent and how GAMMIS will send functional groups. These discussions will describe how similar transaction sets will be packaged and Georgia Medicaid's use of functional group control numbers. The tables below represent the functional group information.

834 (Inbound/Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS01	Functional ID Code	BE	2	
C.7		GS02	Application Sender's Code		2/15	This will be equal to the value in ISA06.
C.7		GS03	Application Receiver's Code		2/15	This will be equal to the value in ISA08.
C.7		GS04	Date		8	Format is CCYYMMDD
C.8		GS05	Time		4/8	Format is HHMM
C.8		GS06	Group Control Number		1/9	Group control number. Must be identical to the value in GE02.
C.8		GS07	Responsible Agency Code	X	1/2	
C.8		GS08	Version/Release/ Industry ID Code		1/12	005010X220A1

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.9		GE	Functional Group Trailer			
C.9		GE01	Number of Transaction Sets Included		1/6	Number of included Transaction Sets.
C.9		GE02	Group Control Number		1/9	The functional group control number. Same value as GS06.

6.3 ST-SE

This section describes Georgia Medicaid's use of transaction set control numbers.

Georgia Medicaid recommends that trading partners follow the guidelines set forth in the TR3 Implementation Guide – start the first ST02 in the first file with 000000001 and increment from there. The TR3 Implementation Guide should be reviewed for how to create compliant transactions set control segments.

834 (Inbound/Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
70		ST	Transaction Set Header			
70		ST01	Transaction Set Identifier Code	834	3	
70		ST02	Transaction Set Control Number		4/9	Transaction control number. Identical to the value in SE02.
70		ST03	Implementation Convention Reference		1/35	005010X220A1. Identical to the value in GS08.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
496		SE	Transaction Set Trailer			
496		SE01	Number of Included Segments		1/10	Total number of segments included in a transaction set including ST and SE segments.
496		SE02	Transaction Set Control Number		4/9	Transaction set control number. Identical to the value in ST02.

6.4 Control Segment Notes

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

6.5 File Delimiters

Georgia Medicaid requests that submitters use the following delimiters on your 834 inbound transactions. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets. These same values will be used on the outbound 834 transactions. Contact the HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590 if there is a need to use a delimiter other than the following:

Data Element: Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The recommend data element delimiter is an asterisk (*).

Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommend repetition separator is a caret (^).

Component-Element: ISA16 defines the component element delimiter to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:).

Data Segment: Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended data segment delimiter is a tilde (~).

7 Georgia Medicaid Specific Business Rules and Limitations

This section describes Georgia Medicaid's business rules, for example:

- Communicating payer specific edits

Before submitting/receiving electronic benefit enrollment and maintenance transactions to/from GAMMIS, please review the appropriate HIPAA Technical Report Type 3 (TR3) Implementation Guide and Georgia Medicaid companion guide.

The following sections outline recommendations, instructions, and conditional data requirements for transactions submitted to/from GAMMIS. This information is designed to help trading partners construct transactions in a manner that will allow GAMMIS to efficiently process transactions.

7.1 Provider Information (Inbound/Outbound)

The implementation date for National Provider Identifier (NPI) was May 23, 2007. Beginning May 23, 2008 for all health care providers, the Provider NPI, Taxonomy Code and Zip Code + the four-digit postal code must be received in the appropriate loops.

When Primary Medicaid Provider (PMP) is sent, it must be the first 2310 Loop, where NM101=Y2 and NM108=SV.

When a Primary Care Provider (PCP) or Primary Care Dentist (PCD) change is sent from a Care Management Organization (CMO), the PCP/PCD must be identified within multiple occurrences of the 2310 Loop, where NM109=NPI (NM108=XX), NM109=MCD (NM108=SV) and NM109=Taxpayer ID (NM108=FI). The NPI, Medicaid ID (MCD) or Taxpayer ID can be sent in any order as long as the NM101=Y2 is first. Each of the three must contain the zip code and the zip code must be the same within all three N403 data elements of the respective PCP or PCD. All data elements must be sent for typical providers; NPI should be excluded for atypical providers. If both the PCP (NM101=P3) and PCD (NM101=QN) are sent for a CMO assignment, they can be sent in up to six consecutive 2310 loops following the PMP (NM101=Y2) 2310 loop. (for example: Y2, P3, P3, P3, QN, QN, QN)

When a PCP preference is sent from the Enrollment Broker (EB) on a new enrollment, all identifiers are not necessary. Any combination of identifiers will be echoed to the CMO in separate 2310 Loop without validation.

PCP changes should be sent with maintenance code 001-Change even if it is the first occurrence for the member.

7.2 Logical File Structure

There can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE) however; the functional groups must be the same type.

7.3 Compliance Checking

Inbound 834 transactions are validated through SNIP Level 4. All other levels will be validated within the GAMMIS.

7.4 Multiple Transactions (ST/SE)

Multiple transactions can be received within a file, however if one of those transactions (ST/SE(s)) contains a compliance error, the entire file will be rejected.

7.5 2100A and 2100C Address Information

When sending a member address change, where the residential address (2100A) and mailing address (2100C) are identical, only the residential address should be sent. If the residential address (2100A) and mailing address (2100C) are not identical, both must be sent.

7.6 MCHB Assignment Program / P4HB Benefit Plan

Managed Care Healthy Babies (MCHB) is the assignment program for members that have eligibility to the Plan for Healthy Babies (P4HB) benefit plan and meet assignment criteria defined in the Managed Care functional area.

7.7 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)

On January 16, 2009, HHS published a final rule adopting ICD-10-CM and ICD-10-PCS to replace ICD-9-CM and ICD-9-PCS in HIPAA transactions, effective implementation date of October 1, 2013. The implementation of ICD-10 was delayed from October 1, 2013 to October 1, 2014 by final rule CMS-0040-F issued on August 24, 2012.

Until that time, October 1, 2014, the codes in ICD-10-CM are not valid for any purpose or use. If Georgia Medicaid receives any transaction that contain the ICD-10-CM or ICD-10-PCS qualifiers the transaction will fail compliance. The submitter will need to correct the compliance failure and resubmit the transaction for processing.

7.8 Name Normalization (CORE Standard)

In an effort to further simplify the eligibility inquiry and response transaction, and reduce the number of non-matches, Georgia Medicaid, in collaboration with the Healthcare Administrative Simplification

Collaborative, which consists of a number of health plans across the state of Georgia, has adopted the Name Normalization standard developed by the Council for Affordable Quality Healthcare (CAQH).

More specifically, Georgia Medicaid has adopted the CORE 258: Phase II Normalizing Patient Last Name Rule, where CORE stands for Committee on Operating Rules for Exchange. This applies to the HIPAA adopted X12N 270/271 eligibility inquiry and response transactions and specifies the requirements for a CORE-certified health plan (or information source), to normalize a person's last name during any name validation or matching process by the health plan (or information source). This CORE rule applies only to certain characters in a person's last name including:

- Punctuation values;
- Uppercase letters;
- Special characters; and
- Name suffixes and prefixes.

Georgia Medicaid applies these normalization rules to both the patient's first name and last name. For additional information on CORE 258, refer to http://www.caqh.org/pdf/CLEAN5010/258-v5010.pdf.

Please Note: The delimiters that may be used in the Patient Last Name according to the CORE standard are limited to space, comma, and forward slash. Any other non-alphabetic delimiter will be viewed as a special character. Valid examples include:

- SMITH SR;
- SMITH, SR; and
- SMITH/SR

7.9 Change based on Edifecs Upgrade

With the recent upgrade to the compliance engine there will be a change to two (2) of the outbound 834 transactions for the value being sent within the BGN08.

- Daily 834 BGN08 = 2 (no change)
- Monthly 834 Roster (24th) with BGN08 = 2 (change)
- Monthly Variance (EOM) with BGN08 = 2 (change)
- Monthly Audit (EOM) with BGN08 = 4 (no change)

8 Georgia Medicaid Specific Program Information for Georgia Families, PeachCare for Kids™ and Foster Care, Adoptive Assistance & Department of Juvenile Justice CMO

This section contains information specifically for the Georgia Families program (GF) the PeachCare for Kids™ program (PCK) and Foster Care (FC), Adoptive Assistance (AA) & Department of Juvenile Justice (DJJ) CMO (FCCMO) for both Inbound and Outbound transactions.

8.1 GF, MCHB and FCCMO Inbound Transactions

GF and MCHB Inbound Transactions are received by the GAMMIS from the Enrollment Broker. GF, MCHB and FCCMO Inbound Transactions are received by the CMO. Inbound 834 transactions could contain:

Enrollment Broker:

- CMO and PCP selections for the potentials sent.
- Information about members that should be in other programs that exclude them from the GF program
- CMO address data
- Special Dis-Enrollments information that will cause a member to be disenrolled from GF or MCHB that cannot be identified in the GAMMIS such as 'moved out of state' or 'incarcerated'.
- Quarterly Reconciliation

CMO:

- PCP and PCD assignments for the members
- Quarterly Reconciliation

8.2 PCK / P4HB Inbound Transactions

Georgia State Children's Health Insurance Program (GA SCHIP) Inbound Transactions and PeachCare for Healthy Babies (GA P4HB) are only received from Georgia Health Partnership via Policy Studies, Incorporated (PSI) and received by the GAMMIS. Inbound 834 transactions could contain:

- Benefit enrollment maintenance information
- New enrollment information
- Changes to the current range of benefits
- Termination of benefits for a member

8.3 GF, MCHB and FCCMO Outbound Transactions

Outbound Transactions are initiated by the GAMMIS and received by the GF Enrollment Broker and CMOs.

Enrollment Broker:

Daily Outbound transaction file is giving information about:

- New potential CMO members
- Changes in eligibility of members sent previously as potential
- Information about members sent in the daily inbound file that failed edits
- Newborns assigned to mothers' CMO (GF only)
- FCCMO and GF "Immediate" assignment changes

CMO:

Daily Outbound transaction file is giving information about:

- Information about members sent in the daily inbound file that failed edits
- Newborns assigned to mothers' CMO (GF only)

- CMO members entering Transition of Care (GF only)
- Demographic changes
- Member merge
- Online changes to assignments
- FCCMO and GF “Immediate” assignment changes

Enrollment Broker and CMO:

Monthly Outbound transaction file is giving information about:

- Complete roster that will contain new, current, terminated, retro and pended members (only GF and MCHB).
- Terminations and void after roster (only GF and MCHB).
- Audit Roster containing all members with an assignment in the next month.

Enrollment Broker and CMO:

Quarterly Outbound transaction file is giving information about:

- Results of reconciliation process (GF Only)

9 Acknowledgements and/or Reports

9.1 The TA1 Interchange Acknowledgement

The TA1 allows the receiver of a file to notify the sender that an invalid interchange structure was received or that problems were encountered. The TA1 verifies only the interchange header (ISA/GS) and trailer (IEA/GE) segments of the file envelope.

For batch and real-time if ISA or GS errors were encountered then the generated TA1 report with the Interchange Header errors will be returned for pickup.

What to look for in the TA1

The TA1 segment indicates whether or not the submitted interchange control structure passed the HIPAA compliance check.

If TA104 is “R” then the transmitted interchange control structure header and trailer were rejected because of errors. The submitter will need to correct the errors and resubmit the corrected file to GAMMIS.

Example:

- TA1*900000001*130321*1700*R*006~

The data elements in the TA1 segment are defined as follows:

TA101 contains the Interchange Control Number (ISA13) from the file to which this TA1 is responding (“900000001” in the example above).

TA102 contains the Interchange Date (“130321” in the example above).

TA103 contains the Interchange Time (“1700” in the example above).

TA104 code indicates the status of the interchange control structure (“R” in the example above). The definition of the code is as follows;

“R” – The transmitted interchange control structure header and trailer are rejected because of errors.

TA105 code indicates the error found while processing the interchange control structure (“006” in the example above). The definitions of the codes are as follows:

Code	Description
000	No Error
001	The InterChange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid InterChange ID Qualifier for Sender
006	Invalid InterChange Sender ID
007	Invalid InterChange ID Qualifier for Receiver
008	Invalid InterChange Receiver ID
009	Unknown InterChange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid InterChange Date Value
015	Invalid InterChange Time Value
016	Invalid InterChange Standards Identifier Value
017	Invalid InterChange Version ID Value
018	Invalid InterChange Control Number Value
019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid InterChange Content (e.g., Invalid GS Segment)
025	Duplicate InterChange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request

Code	Description
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

The TA1 segment will be sent within its own interchange (i.e., ISA-TA1-IEA)

Example of a TA1 within its own interchange

ISA*00* *00* *ZZ*77034 *ZZ*RECEIVER
*130321*1700*^*00501*000000001*0*P*:~TA1*900000001*130321*1700*R*006~IEA*0*0000000
01~

For additional information, consult the Interchange Control Structures, X12.5 Guide. TR3 Implementation Guides may be obtained by logging on to www.wpc-edi.com and following the links to 'EDI Publications' and '5010 Technical Reports.'

9.2 The 999 Implementation Acknowledgement

Each time a 5010 834 X12 file is submitted to GAMMIS, a 999 acknowledgement is sent to the submitter within one business day. A 999 does not guarantee processing of the transaction. It only signifies that GAMMIS received the Functional Group. The following sections explain how to read the 999 to find out whether a file is accepted or rejected. If a Functional Group is accepted, no action is required by the submitter. If the Functional Group is rejected, the submitter must correct the errors and submit the corrected file to GAMMIS.

What to look for in the 999

Locate every AK9 segment. These segments indicate whether or not the submitted Functional Group passed the HIPAA compliance check. If each AK9 segment appears as AK9*A, this means the entire Functional Group was accepted for processing. The transaction will process.

If any AK9 segment begins with AK9*R (Rejected), you should review the AK5 segments for any and all AK5*R values. This segment displays which transaction set or sets have been rejected.

Example of the 999 Acknowledgment

ST*999*0001*005010X231~
AK1*BE*6454*005010X231~
AK2*834*0001~
IK5*A~
AK2*834*0002~
IK3*N4*24**8~
CTX*N403:3050~
IK4*2*116*4~

IK5*R*5~
AK9*R*2*2*1~
SE*11*0001~

AK1: This segment refers to the (GS) group set level of the original file sent to GAMMIS.

Example: AK1*BE*0001*005010X220A1~

- AK101 is equal to GS01 from the original file (e.g., the AK101 of an 834 benefit enrollment and maintenance file would be "BE").
- AK102 is equal to GS06 from the original file (Group Control Number).
- AK103 is equal to GS08 from the original file (EDI Implementation Version).

AK2: This segment refers to the (ST) Transaction set level of the original file sent to GAMMIS.

Example: AK2*834*0001*005010X220A1~

- AK201 is equal to ST01 from the original file (e.g., the AK201 of an 834 benefit enrollment and maintenance file would be "834").
- AK202 is equal to ST02 from the original file (Transaction Set Control Number).
- AK203 is equal to ST03 from the original file (EDI Implementation Version).

IK3: This segment reports errors in a data segment.

Example: IK3*N4*24**8~

- IK301 contains the segment name that has the error. In the example above, the segment name is "N4".
- IK302 contains the numerical count position of this data segment from the start of the transaction set (a "line count"). The erroneous "N4" segment in the example above is the 24th segment line in the Transaction Set. Transaction Sets start with the "ST" segment. Therefore, the erroneous segment in the example is the 26th line from the beginning of the file because the first two segments in the file, ISA and GS, are not part of the transaction set.
- IK303 may contain the loop ID where the error occurred.
- IK304 contains the error code and it states the specific error. In the example above, the code '8' states 'Segment Has Data Element Errors.'

Code	Description
1	Unrecognized segment ID
2	Unexpected segment
3	Required segment missing
4	Loop occurs over maximum times
5	Segment Exceeds Maximum Use

Code	Description
6	Segment not in defined transaction set
7	Segment not in proper sequence
8	Segment has data element errors
I4	Implementation “Not Used” segment present
I6	Implementation Dependent segment missing
I7	Implementation loop occurs under minimum times
I8	Implementation segment below minimum use
I9	Implementation Dependent “Not Used” segment present

CTX: This segment describes the Context/Business Unit. The CTX segment is used to identify the data that triggered the situational requirement in the IK3.

Example:

IK3*N4*24**8
CTX*N403:3005~

IK4: This segment reports errors in a data element.

Example:

IK4*3*116*4~

- IK401 contains the data element position in the segment that is in error. “3” in the example above represents the third data element in the segment.
- IK402 contains the data element reference number as found in the appropriate TR3 Implementation Guide. “116” in the example above represents the N403 data element from the 834.
- IK403 contains the error code and states the specific error. “4” in the example above represents “Data element too short.”

Code	Description
1	Required data element missing
2	Conditional required data element missing
3	Too many data elements
4	Data element too short
5	Data element too long
6	Invalid character in data element
7	Invalid code value
8	Invalid date
9	Invalid time
10	Exclusion condition violated
12	Too many repetitions
13	Too many components
I6	Code value not used in implementation
I9	Implementation dependent data element missing
I10	Implementation “Not Used” data element present

Code	Description
I11	Implementation too few repetitions
I12	Implementation pattern match failure
I13	Implementation Dependent "Not Used" element present

- IK404: May contain a copy of the bad data element

IK5: This segment reports errors in a transaction set.

Example: IK5*R*5~

- IK501 indicates whether the transaction set is:
  - A = Accepted
  - R = Rejected

  Other codes such as M, W, or X are for security decryption purposes but are rarely used.

  "R" in the example above means the transaction set was rejected due to errors.

- IK502 indicates the implementation transaction set syntax error. "5" in the example above indicates "One or More Segments in Error."

  Below is a sample of IK502 error codes. Please refer to the 999 TR3 Implementation Guide for a complete list of these error codes.

Code	Description
1	Transaction Set not supported
2	Transaction Set trailer missing
3	Transaction Set Control Number in Header/Trailer do not match
5	One or more segments in error

AK9: This segment reports the functional group compliance status.

Example: AK9*R*2*2*0~

- AK901 indicates whether the entire functional group is:
  - A = Accepted
  - R = Rejected, the functional group was rejected and was NOT forwarded for further processing. The file will need to be corrected and resubmitted.
  - P = Partially Accepted, at least one transaction set was rejected. The rejected transaction set within the functional group would need to be corrected and resubmitted. (This value should not be used for Georgia Medicaid; an 834 transaction will always be "Accepted" or "Rejected".)

Other codes such as M, W, or X are for security decryption purposes but are rarely used.

- AK902 contains the total number of transaction sets. In the example above, two transaction sets were submitted.
- AK903 contains the number of received transaction sets. In the example above, two transaction sets were received.
- AK904 contains the number of accepted transaction sets in a Functional Group. In the example above, no transaction sets were accepted.
- AK905 contains the Functional Group Syntax Error Code.

Below is a sample of AK905 error codes. Please refer to the 999 TR3 Implementation Guide for a complete list of error codes.

Code	Description
1	Functional group not supported
2	Functional group version not supported
3	Functional group trailer missing
4	Group Control Number in the functional group Header and Trailer do not agree
5	Number of included transaction sets does not match actual count
6	Group Control Number violates syntax
17	Incorrect message length (Encryption only)
18	Message authentication code failed
19	Functional Group Control Number not unique within interchange

For additional information, consult the Implementation Acknowledgment for Health Care Insurance (999) Guide. TR3 Implementation Guides may be obtained by logging onto www.wpc-edi.com and following the links to “HIPAA” and “HIPAA Guides.”

9.3 Report Inventory

There are no acknowledgement reports at this time.

10 Trading Partner Agreements

Providers who intend to conduct electronic transactions with Georgia Medicaid must sign the Georgia Medicaid Trading Partner Agreements. A copy of the agreement is available on the GAMMIS Web Portal page EDI >> Registration Forms.

Trading Partners

An Electronic Data Interchange (EDI) Trading Partner is defined as any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that conducts electronic transactions with Georgia Medicaid. The Trading Partner and Georgia Medicaid acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Each part agrees to take all

steps reasonably necessary to ensure that all electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated there under.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

11 Transaction Specific Information

This section describes how ASC X12N Technical Report Type 3 (TR3) Implementation Guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Georgia Medicaid has something additional, over and above, the information in the TR3s. That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the TR3s internal code listings
- Clarify the use of loops, segments, composite and simple data elements
- Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Georgia Medicaid

In addition to the row for each segment, one or more additional rows are used to describe Georgia Medicaid'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.

11.1 834 (Inbound/Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
32		BGN	Beginning Segment			
32		BGN01	Transaction Set Purpose Code	00, 15, 22		
			Original	00	2	Inbound / Outbound
33		BGN02	Transaction Set Identifier Code		1/50	For Quarterly GF Reconciliation Only Inbound: Current Date (YYMMDD) + "ORIG" or "RESU". Only 7th character validated.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Outbound: Current Date (YYMMDD) + "ACCE" or "REJE".
33-34		BGN05	Time Zone Code	See Notes		Time Zone Codes: 01-24, AD, AS, AT, CD, CS, CT, ED, ES, ET, GM, HD, HS, HT, LT, MD, MS, MT, ND, NS, NT, PD, PS, PT, TD, TS, TT, UT.
			Eastern Standard Time	ES	2	Inbound: GF / MCHB / FCCMO Outbound: All
			Eastern Daylight Time	ED	2	Inbound: GF / MCHB / FCCMO Outbound: All
			Mountain Time	MT	2	Inbound: PCK / P4HB (PSI Vendor)
			Mountain Daylight Time	MD	2	Inbound: PCK / P4HB (PSI Vendor)
			Mountain Standard Time	MS	2	Inbound: PCK / P4HB (PSI Vendor)
35		BGN08	Action Code	2, 4, RX		
			Change (Update)	2	1	Inbound / Outbound: Identifies a transaction of additions, terminations and changes to the current enrollment.
			Verify	4	1	Outbound: Identifies a transaction to verify that the sponsor and payer's systems are synchronized.
36		REF	Transaction Set Policy Number			
36		REF01	Reference Identification Qualifier	38	2	
36		REF02	Master Policy Number		10	Inbound / Outbound: Georgia Medicaid Provider Number.
39	1000A	N1	Sponsor Name			
39	1000A	N102	Plan Sponsor Name			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Plan Sponsor Name		16	Inbound / Outbound GF / MCHB: "GEORGIA FAMILIES"
			Plan Sponsor Name		16	Inbound / Outbound FCCMO: "GA FC AA DJJ CMO"
			Plan Sponsor Name		8	Inbound PCK: "GA SCHIP"
			Plan Sponsor Name		7	Inbound PCK (P4HB): "GA P4HB"
40	1000A	N103	Identification Code Qualifier	24, 94, FI		
			Federal Taxpayer's Identification Number	FI	2	
40	1000A	N104	Sponsor Identifier		10	Inbound / Outbound: GA State Tax ID Number Expressed as: 99-9999999 (including dash).
41	1000B	N1	Payer Name			
41	1000B	N102	Insurer Name			
			Insurer Name		1/60	Inbound / Outbound GF / MCHB / FCCMO: "CMO's / EB's Name"
			Insurer Name		11	Inbound PCK / P4HB: "GA MEDICAID"
42	1000B	N103	Identification Code Qualifier	94, FI, XV		
			Federal Taxpayer's Identification Number	FI	2	
42	1000B	N104	Insurer Identification Code			
			Federal Taxpayer's Identification Number		10	Inbound / Outbound GF / MCHB / FCCMO: "CMO's / EB's Tax ID" Expressed as: 99-9999999 (including dash).
			Federal Taxpayer's Identification Number		10	Inbound PCK / P4HB: "PSI Tax ID" Expressed as: 99-9999999 (including dash).

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
Member Level Detail **Note:** Georgia Medicaid considers the Member as the Subscriber/Member in all reporting situations.						
47	2000	INS	Member Level Detail			Since the 834 transaction has a limit of 10,000 INS segments per transaction, multiple 834 transactions will be used if a provider has > 10,000 enrollment records.
48	2000	INS01	Subscriber Indicator	Y, N		
			Subscriber Indicator (Yes)	Y	1	Inbound / Outbound
48-49	2000	INS02	Individual Relationship Code	See Notes		Relationship Codes: 01, 03-19, 23-26, 31, 38, 53, 60, D2, G8, G9
			Self	18	2	Inbound / Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Foster Child	10	2	Inbound: PCK / P4HB
50	2000	INS03	Maintenance Type Code	See Notes		Maintenance Type Codes: 001, 021, 024, 025, 030
			Change	001	3	Inbound / Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Addition	021	3	Inbound / Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Cancellation or Termination	024	3	Inbound / Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Audit or Compare	030	3	Inbound / Outbound: GF / MCHB / FCCMO
51	2000	INS05	Benefit Status Code	A, C, S, T		
			Active	A	1	Inbound / Outbound

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
52	2000	INS08	Employment Status Code	See Notes		Employment Status Codes: AC, AO, AU, FT, L1, PT, RT, TE
			Active	AC	2	Inbound / Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Terminated	TE	2	Inbound: PCK / P4HB
53	2000	INS10	Handicap Indicator	Y, N		
			Handicap Indicator (Yes)	Y	1	Inbound / Outbound: This field identifies if the member has a Handicap condition. If the member is hearing or visually impaired.
53	2000	INS11	Date Time Period Format Qualifier	D8	2	Inbound / Outbound
54	2000	INS12	Member Date of Death		8	Inbound/Outbound: Member Date of Death. (CCYYMMDD) INS12 is a situational field and should only be populated if applicable. If, INS12 is not sent, do not send INS11.
55	2000	REF	Subscriber Identifier			
55	2000	REF01	Reference ID Qualifier	0F	2	
55	2000	REF02	Subscriber Identifier		12	Inbound/Outbound: 12-digit Georgia Member Medicaid ID.
56	2000	REF	Member Policy Number			
56	2000	REF01	Reference ID Qualifier	1L	2	
56	2000	REF02	Subscriber Identifier		12	Inbound/Outbound: 12-digit Georgia Member Medicaid ID. (This will be the same value that is sent in the REF02, where REF01=0F).

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
2000-REF (Inbound/Outbound) for GF / MCHB / FCC						
57	2000	REF	Member Supplemental Identifier			
57-58	2000	REF01	Reference ID Qualifier	See Notes		Reference ID Qualifiers: 17, 23, 3H, 4A, 6O, ABB, D3, DX, F6, P5, Q4, QQ, ZZ
			Mutually Defined	ZZ	2	
53	2000	REF02	Subscriber Identifier			This REF02 will have a string of 29 bytes of contiguous data described below. FCCMO will have 38 bytes. For the below fields: "Required" means that it must be populated on Inbound transactions if this segment is present. "Situational" means that it is required if known.
			Aid Category (Required A/N)		3	Aid Category will be zeros (000) in the outbound for record types 15, 17, and 21-26 or when not available.
			Major Program Code (Required A/N)	M, P, H, F	1	'M' – Medicaid (GF) 'P' – Peachcare (GF) 'H' – Medicaid (MCHB) 'F' – FosterCare (FCCMO)
			Medicare ID (Situational A/N)		12	
			Ethnicity Code (Situational A/N)	L, N	1	'L' – Latino/Hispanic 'N' – Non-Latino/Hispanic
			Pregnancy Due Date (Situational)		6	Date Format: YYMMDD
			Pregnancy Termination Date (Situational)		6	Date Format: YYMMDD
			County of Custody (Situational – only FCCMO types)		3	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Eligibility End Date (Situational – only FCCMO types)		6	Date Format: YYMMDD
2000-REF (Inbound) for PCK / P4HB						
57	2000	REF	Member Supplemental Identifier			
57-58	2000	REF01	Reference ID Qualifier	See Notes		Reference ID Qualifiers: 17, 23, 3H, 4A, 6O, ABB, D3, DX, F6, P5, Q4, QQ, ZZ
			Mutually Defined	ZZ	2	
53	2000	REF02	Subscriber Identifier			This REF02 will have a string of 17 bytes of contiguous data described below. For the below fields: "Required" means that it must be populated on Inbound transactions if this segment is present. "Situational" means that it is required if known.
			Aid Category (Required A/N)		3	
			Major Program Code (Required A/N)	M, P	1	'M' – Medicaid 'P' – Peachcare
			Filler (Situational A/N)		12	
			Ethnicity Code (Situational A/N)	L, N	1	'L' – Latino/Hispanic 'N' – Non-Latino/Hispanic
57	2000	REF	Member Supplemental Identifier			
57-58	2000	REF01	Reference ID Qualifier	See Notes		Reference ID Qualifiers: 17, 23, 3H, 4A, 6O, ABB, D3, DX, F6, P5, Q4, QQ, ZZ
			Case Number	3H	2	
			Client Number	23	2	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Prior Identifier Number	Q4	2	
			Client Reporting Category	17	2	
58	2000	REF02	Subscriber Identifier			
			Case Number: A/N (12) Record Type Code: A/N (2)		14	Inbound / Outbound Where REF01=3H: Case Number is not sent for record types 15, 17, 18 and 21-26. Case Number is not sent to the EB for record types 06, 07, 18, 92 (Disenroll Fail) and 93 (Enroll Fail). **Note:** Valid Values for the Record Type Codes are listed in Appendix 12.
			Client Number		1/30	Outbound Where REF01=23: GF / MCHB / FCCMO: Alternate Member Medicaid ID and SSN (member merge). GF (Recon): CMO Member ID (for Recon).
			Prior Identifier Number		12	Outbound (Recon) Where REF01=Q4: GF: Target Medicaid Member ID
			Client Reporting Category		1/30	Outbound Where REF01=17: GF / MCHB: This is a free-form field for the EB to pass through to the CMO member's unique health status. Examples may

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						include “pregnant”, “currently hospitalized”, etc.
59	2000	DTP	Member Level Dates			This occurrence of the DTP segment can repeat multiple times.
59-60	2000	DTP01	Date/Time Qualifier	See Notes		Date/Time Qualifiers: 050, 286, 296, 297, 300, 301, 303, 336-341, 350, 351, 356, 357, 383, 385, 386, 393, 394, 473, 474.
			Eligibility Begin	356	3	
			Eligibility End	357	3	
			Received	050	3	
			Maintenance Effective	303	3	
61	2000	DTP03	Date Time Period			A date format of 22991231 indicates ongoing enrollment.
			Eligibility Begin (CCYYMMDD)		8	Inbound/Outbound Where DTP01=356 Represents current eligibility only.
			Eligibility End (CCYYMMDD)		8	Inbound/Outbound Where DTP01=357 Represents current eligibility only.
			Received (CCYYMMDD)		8	Inbound PCK: Where DTP01=050 (Recertification Date)
			Maintenance Effective (CCYYMMDD)		8	Inbound PCK: Where DTP01=050 (Premium Effective Date)
62	2100A	NM1	Member Name			
62-63	2100A	NM101	Entity Identifier Code	IL, 74		

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Insured or Subscriber	IL	2	Inbound/Outbound: Use this code for enrolling a new member or updating a member with no change in identifying information.
			Corrected Insured	74	2	Outbound: Use this code if this transmission is correcting the identifier information on a member already enrolled. Usage of this code requires the sending of an NM1 with code '70' in Loop 2100B.
63	2100A	NM102	Entity Type Qualifier	1	1	Inbound/Outbound
63	2100A	NM103	Subscriber Last Name		1/60	Inbound/Outbound: Member Last Name.
63	2100A	NM104	Subscriber First Name		1/35	Inbound/Outbound: Member First Name.
63	2100A	NM105	Subscribers Middle Name		1	Inbound/Outbound: Member Middle Initial.
63	2100A	NM107	Subscribers Suffix Name		1/10	Inbound/Outbound: Member Suffix.
64	2100A	NM108	Identification Code Qualifier	34, ZZ		
			Social Security Number	34	2	Inbound/Outbound: Only populated if valid SSN based on SSA algorithm is sent within 2100A-NM109.
64	2100A	NM109	Member Identifier		9	Inbound/Outbound: Member Social Security Number. Only populated if valid SSN based on SSA algorithm.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						If no SSN is available, the 2100A-NM108/NM109 data elements are not populated. The value of '000000000' is not valid.
65	2100A	PER	Member Communications Numbers			
66	2100A	PER03	Communication Number Qualifier			Communication Qualifiers: AP, BN, CP, EM, EX, FX, HP, TE, WP.
			Communication Number Qualifier	TE	2	Inbound/Outbound
			Communication Number Qualifier	EM	2	Inbound/Outbound
66	2100A	PER04	Communication Number	See Notes	1/75	Inbound/Outbound: If, PER03=TE (Member Contact Number) If, PER03=EM (Member Email Address) **NOTE**: Only allowed value is a 10 digit phone number until CSR 997 is implemented. Once CSR 997 is implemented, Only 1 email address is allowed within this entire 2100A-PER segment.
66	2100A	PER05	Communication Number Qualifier			Communication Qualifiers: AP, BN, CP, EM, EX, FX, HP, TE, WP.
			Communication Number Qualifier	TE	2	Inbound/Outbound
			Communication Number Qualifier	EM	2	Inbound/Outbound
67	2100A	PER06	Communication Number	See Notes	1/75	Inbound/Outbound: If, PER03=TE (Member Contact Number)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						If, PER03=EM (Member Email Address) **NOTE**: Only allowed value is a 10 digit phone number until CSR 997 is implemented. Once CSR 997 is implemented, Only 1 email address is allowed within this entire 2100A-PER segment.
67	2100A	PER07	Communication Number Qualifier			Communication Qualifiers: AP, BN, CP, EM, EX, FX, HP, TE, WP.
			Communication Number Qualifier	TE	2	Inbound/Outbound
			Communication Number Qualifier	EM	2	Inbound/Outbound
67	2100A	PER08	Communication Number	See Notes	1/75	Inbound/Outbound: If, PER03=TE (Member Contact Number) If, PER03=EM (Member Email Address) **NOTE**: Only allowed value is a 10 digit phone number until CSR 997 is implemented. Once CSR 997 is implemented, Only 1 email address is allowed within this entire 2100A-PER segment.
68	2100A	N3	Member Residence Street Address			
68	2100A	N301	Subscriber Address		1/55	Inbound/Outbound: Required when enrolling or changing a Members Residential Address.
68	2100A	N302	Subscriber Address (Line 2)		1/55	Inbound/Outbound:

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Member Residential Address Line 2, when applicable.
69	2100A	N4	Member City, State, Zip Code			
69	2100A	N401	Subscriber City		2/30	Inbound/Outbound: Required when enrolling or changing a Member's Residential Address.
69	2100A	N402	Subscriber State		2	Inbound/Outbound: Required when enrolling or changing a Member's Residential Address.
70	2100A	N403	Subscriber Zip Code		5 or 9	Inbound/Outbound: Required when enrolling or changing a Member's Residential Address.
70	2100A	N405	Location Qualifier	60, CY		
			County	CY	2	Inbound/Outbound
70	2100A	N406	Location Identification Code		3	Inbound/Outbound: Member three digit County Code **Note:** Valid Values for the County Codes are listed in Appendix 15.
71	2100A	DMG	Member Demographics			
71	2100A	DMG01	Date Qualifier	D8	2	Inbound/Outbound: Required when enrolling or changing a Members Demographics.
71	2100A	DMG02	Member Birth Date (CCYYMMDD)		8	Inbound/Outbound: Required when enrolling or changing a Members Demographics.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
72	2100A	DMG03	Gender Code	F, M, U	1	Inbound/Outbound: Required when enrolling or changing a Members Demographics.
72-73	2100A	DMG05-1	Race or Ethnicity Code	7, 8, A-J, N, O, P, Z	1	Inbound/Outbound: Required when enrolling or changing a Members Demographics.
79	2100A	ICM	Member Income			
79	2100A	ICM01	Frequency Code	1-9, B, C, H, Q, S, U		
			Monthly	4	1	Inbound PCK / P4HB: Created per affected member.
80	2100A	ICM02	Wage Amount		1/10	Inbound PCK / P4HB: Gross Income.
81	2100A	AMT	Member Policy Amounts			
81	2100A	AMT01	Amount Qualifier Code	See Notes		Amount Qualifiers: B9, C1, C2, EBA, FK, P3, R.
			Premium Amount	P3	2	
81	2100A	AMT02	Monetary Amount		1/10	Inbound PCK: Premium Amount.
84	2100A	LUI	Member Language			If multiple LUI segments are received, ONLY the first occurrence will be used for processing.
84	2100A	LUI01	Identification Code Qualifier	LD, LE		
			ISO 639 Language Codes	LE	2	Inbound / Outbound
85	2100A	LUI02	Language Code		3	Inbound/Outbound: Language Code from external code source ISO 639.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Note: Previous system this information was captured within LUI03. http://www.loc.gov/standards/iso639-2/php/code_list.php
86	2100B	NM1	Incorrect Member Name			
86	2100B	NM101	Entity Identifier Code	70	2	Inbound/Outbound
87	2100B	NM103	Prior Incorrect Last Name		1/60	Inbound/Outbound: When applicable corrected Member Last Name.
87	2100B	NM104	Prior Incorrect First Name		1/35	Inbound/Outbound: When applicable corrected Member First Name.
87 -88	2100B	NM108	Identification Code Qualifier	34, ZZ		
			Social Security Number	34	2	Inbound/Outbound: Only sent if 2100B-NM109 is sent.
88	2100B	NM109	Prior Incorrect Insured Identifier		12	Inbound/Outbound: When applicable corrected Member ID.
89	2100B	DMG	Incorrect Member Demographics			
89	2100B	DMG01	Date Qualifier	D8	2	Inbound/Outbound: Required when changing previously supplied demographics.
90	2100B	DMG02	Member Birth Date (CCYYMMDD)		8	Inbound/Outbound: Required when changing previously supplied demographics.
90	2100B	DMG03	Gender Code	M, F, U	1	Inbound/Outbound: Required when changing

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						previously supplied demographics.
92	2100C	NM1	Member Mailing Address			
92	2100C	NM101	Entity Identifier Code	31	2	Inbound/Outbound
92	2100C	NM102	Entity Type Qualifier	1	1	Inbound/Outbound
94	2100C	N3	Member Mail Street Address			
94	2100C	N301	Member Mailing Address		1/55	Inbound/Outbound: When applicable Member Mailing Address.
94	2100C	N302	Additional Member Mailing Address		1/55	Inbound/Outbound: When applicable Member Mailing Address.
95	2100C	N4	Member City, State, Zip Code			
95	2100C	N401	Member Mailing City		2/30	Inbound/Outbound: When applicable Member Mailing City.
95	2100C	N402	Member Mailing State		2	Inbound/Outbound: When applicable Member Mailing State.
96	2100C	N403	Member Mailing Zip Code		5 or 9	Inbound/Outbound: When applicable Member Mailing Zip Code.
122	2100G	NM1	Responsible Person			Information within this Responsible Person Loop is for the Head of Household.
123-124	2100G	NM101	Entity Identifier Code	See Notes		Entity Identifier Codes: 6Y, 9K, E1, EI, EXS, GB, GD, J6, LR, QD, S1, TZ, X4.
			Person or Entity Legally Responsible	E1	2	Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Executor or Estate	EI	2	Inbound: PCK / P4HB

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Ex-Spouse	EXS	3	Inbound: PCK / P4HB
			Guardian	GD	2	Inbound: PCK / P4HB
			Power of Attorney	J6	2	Inbound: PCK / P4HB
			Responsible Party	QD	2	Inbound: PCK / P4HB
124	2100G	NM102	Entity Type Qualifier	1	1	Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
124	2100G	NM103	Responsible Party Last Name		1/60	Outbound GF / MCHB: Head of Household Last Name. Outbound FCCMO: Authorized Rep Last Name. Inbound PCK / P4HB: Parent 1 Last Name.
124	2100G	NM104	Responsible Party First Name		1/35	Outbound GF / MCHB: Head of Household First Name. Outbound FCCMO: Authorized Rep First Name. Inbound PCK / P4HB: Parent 1 First Name.
124	2100G	NM105	Responsible Party Middle Initial Name		1	Outbound GF / MCHB: Head of Household Middle Initial. Outbound FCCMO: Authorized Rep Middle Initial. Inbound PCK / P4HB: Parent 1 Middle Initial.
125	2100G	NM107	Responsible Party Suffix		1/10	Outbound GF / MCHB: Head of Household Suffix.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Outbound FCCMO: Authorized Rep Suffix. Inbound PCK / P4HB: Parent 1 Name Suffix.
126	2100G	PER	Member Communications Numbers			
127	2100G	PER03	Communication Number Qualifier			Communication Number Qualifiers: AP, BN, CP, EM, EX, FX, HP, TE, WP.
			Telephone	TE	2	Outbound: GF / MCHB
			Home Phone Number	HP	2	Inbound: PCK / P4HB
127	2100G	PER04	Communication Number		10	Outbound: GF / MCHB Where, PER03=TE. Inbound: PCK / P4HB Where, PER03=HP.
127	2100G	PER05	Communication Number Qualifier			Communication Number Qualifiers: AP, BN, CP, EM, EX, FX, HP, TE, WP.
			Work Phone Number	WP	2	Inbound: PCK / P4HB
128	2100G	PER06	Communication Number		10	Inbound: PCK / P4HB
130	2100G	N4	Responsible Person City, State, Zip Code			
130	2100G	N401	City Name		2/30	Outbound GF/MCHB: Head of Household City. Inbound PCK / P4HB: Parent 1 City.
131	2100G	N402	State		2	Outbound GF/MCHB: Head of Household State Inbound PCK / P4HB: Parent 1 State.
131	2100G	N403	Postal Code			Outbound GF/MCHB: Head of Household Zip Code. Inbound PCK / P4HB:

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Parent 1 Zip Code.
140	2300	HD	Health Coverage			See Appendix 13 and 14 for additional information.
140-141	2300	HD01	Maintenance Type Code	See Notes		Maintenance Type Codes: 001, 002, 021, 024, 025, 026, 030, 032.
			Change	001	3	Inbound / Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Delete	002	3	Inbound: PCK / P4HB
			Addition	021	3	Inbound / Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Cancellation or Termination	024	3	Inbound / Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Audit or Compare	030	3	Inbound / Outbound: GF / MCHB / FCCMO
141	2300	HD03	Insurance Line Code	See Notes		Insurance Line Codes: AG, AH, AJ, AK, DCP, DEN, EPO, FAC, HE, HLT, HMO, LTC, LTD, MM, MOD, PDG, POS, PPO, PRA, STD, UR, VIS.
			Health Maintenance Organization	HMO	3	Inbound / Outbound: GF / MCHB / FCCMO
			Exclusive Provider Organization	EPO	3	Inbound: PCK / P4HB
141	2300	HD04	Plan Coverage Description			Inbound/Outbound GF / MCHB / FCCMO: This HD04 will have a string of 35 bytes of contiguous data described below:
			Assignment Type Code (A/N)		4	
			Service Region Code (A/N)		2	
			Redetermination Date		4	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			(A/N) – YYMM (Previously – Plan ID)			
			Assignment Reason Code (A/N)		4	
			Assignment Change Reason Code (A/N)		4	
			Open Enrollment Month/Day (MMDD)		4	
			Cap Category (A/N) (Previous name Cohort ID)		5	
			Record Counter (N)		6	
			Response Code (A/N)		1	
			Co-Pay-Required (A/N)		1	
141	2300	HD04	Plan Coverage Description			Inbound PCK / P4HB: This HD04 will have a string of 13 bytes of contiguous data described below:
			Coverage Plan Type (A/N)	A	1	
			Plan Aid Category (A/N)		3	
			Plan Aid Term Reason (A/N)		3	
			Filler (A/N)		1	
			Plan Confidentiality Code (A/N)	F, P, N, space	1	'F' – Foster Care 'P' – Peachcare 'N' – None 'Space' – None
			Plan Num of Adults (Required A/N)		2	
			Plan Num of Children (Required A/N)		2	
141	2300	HD05	Coverage Level Code			Coverage Level Codes: CHD, DEP, E1D-E3D, E5D-ED9, ECH, EMP, ESP, FAM, IND, SPC, SPO, TWO.
			Individual	IND	3	Inbound / Outbound

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
143	2300	DTP	Health Coverage Dates			This occurrence of the DTP segment can repeat multiple times.
143	2300	DTP01	Date/Time Qualifier	See Notes		Date/Time Qualifiers: 300, 303, 343, 348, 349, 543, 695.
			Benefit Begin	348	3	
			Benefit End	349	3	
			Maintenance Effective	303	3	
144	2300	DTP03	Date Time Period			A date format of 22991231 indicates ongoing enrollment.
			Benefit Begin (CCYYMMDD)		8	Inbound / Outbound GF / MCHB / FCCMO: Where DTP01=348
			Benefit End (CCYYMMDD)		8	Inbound / Outbound GF / MCHB / FCCMO: Where DTP01=349
			Maintenance Effective (CCYYMMDD)		8	Outbound GF / MCHB / FCCMO: Where DTP01=303
Provider Information **PCP Provider Identification for Outbound Transactions:** PCP Information in the outbound is not verified by GAMMIS. It is sent to the CMO exactly as it is received by the EB to indicate the member's preference regarding the new PCP assignment. The data is not intended to be complete or accurate. The NPI can be sent within the 2310-NM109 where NM108=XX for a typical provider. For all providers, the Tax ID can be sent within the 2310-NM109 where NM108=FI and NM109=Tax ID AND the Medicaid ID can be sent within the 2310 Loop, where NM108=SV and NM109 = Medicaid ID. When multiple values are sent, they will be in separate occurrences of the 2310 Loop.						
153	2310	NM1	Provider Name			
153-154	2310	NM101	Entity Identifier Code			Entity Identifier Codes: 1X, 3D, 80, FA, OD, P3, QA, QN, Y2.
			Managed Care Organization	Y2	2	Inbound / Outbound: GF / MCHB / FCCMO

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Inbound: PCK / P4HB
			Primary Care Provider (PCP)	P3	2	Inbound / Outbound: GF / MCHB / FCCMO Inbound: PCK / P4HB
			Primary Care Dentist (PCD)	QN	2	Inbound / Outbound: FCCMO Inbound: PCK / P4HB
154	2310	NM102	Entity Type Qualifier	1, 2	1	Inbound / Outbound: '1' – Person '2' – Non-Person
154	2310	NM103	Provider Last Name or Organization Name			
			Organization Name		8	Inbound PCK: "GA SCHIP"
			Organization Name		7	Inbound PCK (P4HB): "GA P4HB"
154	2310	NM108	Identification Code Qualifier	34, FI, SV, XX		
			Service Provider Number	SV	2	
			National Provider Identifier (NPI)	XX	2	
			Federal Taxpayer's Identification Number	FI	10	
154	2310	NM109	Identification Code			Inbound / Outbound: GA State Tax ID Number Expressed as: 99-9999999 (including dash).
			Service Provider Number		10	Inbound / Outbound: Where, NM108=SV Georgia Medicaid Provider ID.
			National Provider Identifier (NPI)		10	Inbound / Outbound: Where, NM108=XX NPI
			Federal Taxpayer's Identification Number		10	Inbound / Outbound:

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Where, NM108=FI Federal Tax ID Number Expressed as: 99-9999999 (including dash).
155	2310	NM110	Entity Relationship Code	25, 26, 72		
			Established Patient	25	2	Inbound / Outbound
			Not Established Patient	26	2	Inbound / Outbound
157	2310	N4	Provider City, State, Zip Code			
157 157	2310	N401	City Name		2/30	Inbound/Outbound GF / MCHB / FCCMO: If applicable, Primary Care Provider City Inbound PCK / P4HB: Managed Care Organization City
157	2310	N402	State		2	Inbound/Outbound GF / MCHB / FCCMO: If applicable, Primary Care Provider State Inbound PCK / P4HB: Managed Care Organization State
158	2310	N403	Zip Code		5 or 9	Inbound/Outbound GF / MCHB / FCCMO: If applicable, Primary Care Provider Zip Code Inbound PCK / P4HB: Managed Care Organization Zip Code
159	2310	PER	Provider Communications Numbers			
160	2310	PER03	Communication Number Qualifier			Communication Number Qualifiers: AP, BN, CP, EM, EX, FX, HP, TE, WP.
			Telephone	TE	2	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
160	2310	PER04	Communication Number		10	Inbound / Outbound GF / MCHB / FCCMO: Primary Care Provider Telephone Number.
164	2320	COB	Coordination of Benefits			
164	2320	COB01	Payer Responsibility Sequence Number Code	P, S, T, U		
			Unknown	U	1	Inbound / Outbound GF / MCHB / FCCMO:
164-165	2320	COB03	Coordination of Benefits Code	1, 5, 6	1	Inbound / Outbound GF / MCHB / FCCMO: '1' – Coordination of Benefits '5' – Unknown '6' – No Coordination of Benefits
For GF / MCHB / FCCMO Only: The following REF and DTP segments within the 2320 and NM1 segment within the 2330 will be populated by GAMMIS on the outbound 834 when data is available. Any 2320 and 2330 data that is sent on the inbound will not be read by the GAMMIS and, in the event of an edit error on some other record for the same INS segment, will not be returned in the error.						
166	2320	REF	Additional Coordination of Benefits Identifiers			
166	2320	REF01	Reference Identification Qualifier	60, 6P, SY, ZZ		
			Group Number	6P	2	
			Account Suffix Code	60	2	
167	2320	REF02	Reference Identification			
			Group Number		1/50	Outbound GF / MCHB / FCCMO: Coverage Code, Where, REF01=6P.
			Account Suffix Code		1/50	Outbound GF / MCHB / FCCMO:

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Policy Number, Where, REF01=60.
168	2320	DTP	Coordination of Benefits Eligibility Dates			This occurrence of the DTP segment can repeat multiple times.
168	2320	DTP01	Date Time Qualifier	344, 345	3	
168	2320	DTP03	Coordination of Benefits Date (CCYYMMDD)		8	Outbound GF / MCHB / FCCMO: COB Benefits Begins, Where, DTP01=344. COB Benefits Ends, Where DTP01=345.
169	2330	NM1	Coordination of Benefits Related Entity			
169	2330	NM101	Entity Identifier Code	36, GW, IN		
			Insurer	IN	2	Outbound: GF / MCHB / FCCMO
170	2330	NM102	Entity Type Qualifier	2	1	Outbound: GF / MCHB / FCCMO
170	2330	NM103	Name Last or Organization Name		1/60	Outbound GF / MCHB / FCCMO: Insurance Company Name.
170	2330	NM108	Identification Code Qualifier	FI, NI, XV		
			National Association of Insurance Commissioners (NAIC) Identification	NI	2	Outbound: GF / MCHB
170	2330	NM109	Identification Code		2/80	Outbound GF / MCHB / FCCMO: Other Insurance Carrier Code.

12 Appendices (Record Type Codes 2000-REF02, where REF01=3H)

Record Type Codes that will be sent and/or received within the last two positions of the 2000-REF02, where REF01=3H.

12.1 Daily Outbound Record Type Codes for GF sent to EB and CMO

EB	CMO	Value
Yes		01 – Potential Eligible
Yes		06 – Ineligible
Yes	Yes	07 – Member Merge-Source
Yes	Yes	08 – Member Merge-Target (Unmerge)
Yes	Yes	14 – Enrolled Newborns
	Yes	15 – Enrolled Members in Foster Care (Ongoing transition)
Yes	Yes	17 – Change occurred that didn't affect the eligibility of a member
Yes	Yes	18 – Member Void: A CMO Assignment has been voided (Assignment void from GF EOM process or via an ad hoc assignment update. This will be sent with transaction type: 024
	Yes	21 – GAPP – PA (Ongoing transition)
	Yes	22 – Deeming Waiver (Ongoing transition)
	Yes	23 – CMS (Ongoing transition)
	Yes	24 - SSI (Ongoing transition)
	Yes	25 - Hospice (Ongoing transition)
	Yes	26 – Waiver (Ongoing transition)
Yes	Yes	27 – Change occurred to the CMO assignment. Current assignment is sent with transaction type 030. Historical assignment is sent with transaction type 024
Yes	Yes	28 – GF Enroll Immediate Women's Health Medicaid (WHM) or Pregnancy

EB	CMO	Value
Yes	Yes	32 – GF Disenroll Immediate
Yes	Yes	33 – GF Enroll Immediate
Yes	Yes	34 – GF Enroll Immediate - PCK
Yes		92 – Disenrollment records sent that did not pass edits
Yes		93 – Enrollment records sent that did not pass edits.
Yes		94 – Address records sent that did not pass edits
Yes		95 – Special disenrollment records sent that did not pass edits
	Yes	96 – PCP Change records sent that did not pass edits
Yes		99 – These are records sent with an invalid record type did not pass edits

12.2 Daily Outbound Record Type Codes for MCHB sent to EB and CMO

EB	CMO	Value
Yes		01 – Potential Eligible
Yes		06 – Ineligible
Yes	Yes	07 – Member Merge-Source
Yes	Yes	08 – Member Merge-Target (Unmerge)
Yes	Yes	17 – Change occurred that didn't affect the eligibility of a member
Yes	Yes	18 – Member Void: A CMO Assignment has been voided (Assignment void from GF EOM process or via an ad hoc assignment update. This will be sent with transaction type: 024
Yes	Yes	27 – Change occurred to the CMO assignment. Current assignment is sent with transaction type 030. Historical assignment is sent with transaction type 024
Yes	Yes	29 – MCHB Enroll Immediate
Yes		92 – Disenrollment records sent that did not pass edits
Yes		93 – Enrollment records sent that did not pass edits.
Yes		94 – Address records sent that did not pass edits
Yes		95 – Special disenrollment records sent that did not pass edits

EB	CMO	Value
	Yes	96 – PCP Change records sent that did not pass edits
Yes		99 – These are records sent with an invalid record type did not pass edits

12.3 Daily Outbound Record Type Code for FCCMO sent to EB and CMO

EB	CMO	Value
Yes	Yes	07 – Member Merge-Source
Yes	Yes	08 – Member Merge-Target (Unmerge)
Yes	Yes	17 – Change occurred that didn't affect the eligibility of a member
Yes	Yes	30 – FCCMO Disenroll Immediate
Yes	Yes	31 – FCCMO Enroll Immediate
	Yes	96 – PCP Change records sent that did not pass edits
Yes		99 – These are records sent with an invalid record type did not pass edits

12.4 Monthly Roster Outbound Record Type Codes for GF sent to EB and CMO

EB	CMO	Value
Yes	Yes	09 – New Members on Roster
Yes	Yes	10 – Current Members on Roster
Yes	Yes	11 – Terminated Members on Roster
Yes	Yes	12 – Retroactive Members on Roster
Yes	Yes	13 – Pended Members on Roster

12.5 Monthly Roster Outbound Record Type Codes for MCHB sent to EB and CMO

EB	CMO	Value
Yes	Yes	09 – New Members on Roster
Yes	Yes	10 – Current Members on Roster
Yes	Yes	11 – Terminated Members on Roster

12.6 Monthly Variance Outbound Record Type Codes for GF and MCHB sent to EB and CMO

EB	CMO	Value
Yes	Yes	11 – Terminated Members on Roster
Yes	Yes	18 – Void

12.7 Monthly Audit Outbound Record Type Codes for GF, MCHB and FCCMO sent to EB and CMO

EB	CMO	Value
Yes	Yes	10 – Current Members on Roster

12.8 Quarterly Recon Outbound Record Type Codes for GF and MCHB sent to EB and CMO

EB	CMO	Value
Yes	Yes	10 – Current Members on Roster

12.9 Daily Inbound Record Type Codes for GF and MCHB sent to GAMMIS

EB	CMO	Value
Yes		02 – Disenrollment
Yes		03 – Enrollment
Yes		04 – Address Change
Yes		05 – Special Disenrollment
	Yes	16 – PCP Change

12.10 Quarterly Recon Inbound Record Type Codes for GF and MCHB sent to GAMMIS

EB	CMO	Value
Yes	Yes	10 – Current Members on Roster

13 Appendices (Plan Coverage Description 2300-HD04)

13.1 Assignment Type Codes, Assign Reason Codes, Change Reason Codes and Response Codes (Information within HD04)

Assignment Type Codes – HD04 positions 1-4

Data Element Name	Valid Values
Assignment Type Code	CMO: CMO
	CMS: Children Medical Service
	GAPP: Georgia Pediatric Program
	GBHC: Georgia Better Health Care
	LHSP: Hospice Physician Lock-In
	LICS: Physician for Controlled Substance
	LI30: Pharmacy Lock-in Spec Pharmacy
	LI43: Physician Lock-in Spec Physician
	LI72: Dialysis Lock-in Spec Provider
	MHSP: Medicare Hospice
	REVW: On Review Indicator
	DSM: Disease State Management

13.2 GF, MCHB and FCCMO Assignment Codes – HD04 positions 11-14

Assignment Reason Codes in the 834 have two purposes:

1. Potential – Inform the EB of a potential eligible – begin outreach

Assign Reason Code	Description
650	CMO AUTO ASSIGN-NO SELECTION
672	CMO PREGNANT OR WHM-NO SELECTION
711	CMO PEACHCARE FOR KIDS-NO SELECTION

2. Assignment – New assignment for Member

   GF, MCHB and FCCMO Assignment Reason Codes – Expected from EB, Added by DCH, Added by MMIS, Recon Process, Description and Business Rules to Apply Change Reason Code.

Assignment Reason Codes	EB, DCH, MMIS, RECON	Business Rules to Apply Change Reason Code
299	EB	CONVERSION UNKNOWN ASGN RSN
632	MMIS	FC START AA MOVING FROM FC-DJJ
634	MMIS	FC START FC-DJJ MOVING FROM AA
648	RECON	RECONCILIATION ADJUSTMENT START
649	EB	CMO ONLINE MEMBER ENROLLMENT
650	MMIS	CMO AUTO ASSIGN-NO SELECTION
651	EB	CMO AUTO ASSIGN-SELECTION
652	EB	CMO MEMBER CHOICE CHANGE
653	EB	CMO HIGH SECURITY ASSIGN OVR
654	MMIS	CMO AUTO RE-ENROLLMENT (Reinstatement)
656	MMIS	CMO-INFANT-ENROLL
657	EB	CMO REASSGN MRL OR RLGS REASON
658	EB	CMO REASSGN TO SAME FAMILY PLN
659	MMIS	GF ENROLLMENT MOVING FROM FC/AA/DJJ
660	EB	CMO REASSGN FOR POOR QTL CARE
661	EB	CMO HISTORIC ENROLLMENT
662	EB	CMO REASSGN FOR SERV NOT PROV
663	EB	CMO OPN ENRL NEW CHOICE
671	EB	CMO YEARLY OPEN ENROLLMENT OVRD
672	MMIS	CMO PREGNANT OR WHM-NO SELECTION
673	EB	CMO PREGNANT OR WHM-SELECTION
681	MMIS	CMO PREGNANT OR WHM-ASSIGN SAME FAMILY
682	MMIS	CMO PREGNANT OR WHM-ASSIGN HISTORIC
688	EB	CMO FAMILY ENROLLMENT

Assignment Reason Codes	EB, DCH, MMIS, RECON	Business Rules to Apply Change Reason Code
689	EB	CMO INTERNAL REGION CHANGE
694	MMIS	CMO MEMBER REASSIGNED (County Switch Region Change)
699	EB	CMO SPECIAL MASS TRANSFER
711	MMIS	CMO PEACHCARE FOR KIDS-NO SELECTION
712	EB	CMO PEACHCARE FOR KIDS-SELECTION
713	MMIS	CMO PEACHCARE FOR KIDS-ASSIGN SAME FAMILY
714	MMIS	CMO PEACHCARE FOR KIDS-ASSIGN HISTORIC
715	MMIS	PCK/FC/DJJ NON-SELECTION AUTO ENROLLMENT
899	EB	CMO MASS CHANGE ASSIGNMENT
981	EB	MCHB AUTO RE-ENROLLMENT (P4HB only)
982	EB	MCHB MASS CHANGE ASSIGNMENT (P4HB only)
983	EB	MCHB OVERLAP GF / TRANSITION FROM GF (P4HB only)
984	EB	MCHB REASSIGN TO GF CMO (P4HB only)
994	MMIS	FC NON-SELECTION AUTO ENROLLMENT
996	MMIS	AA NON-SELECTION AUTO ENROLLMENT
997	MMIS	DJJ NON-SELECTION AUTO ENROLLMENT
998	MMIS	AA-OPT IN ENROLLMENT
M675	MMIS	Identifies the Assignment Reason Code for a New Lock-in Span Created on the Target Table Due to Merge Process
M995	MMIS	DEFAULT MERGE RSN FOR MBR MRG
MXXX	MMIS	Any Assignment Reason Code with a Preceding variable of “M” identifies a Source Span Moved to Target Table Due to the merge Process
V995	MMIS	DEFAULT VOID RSN FOR MBR MRG
VXXX	MMIS	Any Assignment Reason Code with a Preceding variable of “V” identifies a Source Span partially Overlaps Target Span that is Moved to Target Table and is Voided Due to the Merge Process

13.3 GF and MCHB Change Reason Codes HD04 positions 15-18

Information that will be sent to the EB and CMO’s due to Recon Process, Void and Merge Process.

Change Reason Codes sent to the EB and CMOs due to the Recon Process:

Change Reason Code	834 Transaction Direction	Long Description
647	Outbound 834	Recon chg for lock-in adjustment
CNR	Outbound 834	Recon void change reason code

Change Reason Code to Illustrate a Void:

Change Reason Code	834 Transaction Direction	Long Description
CN	Outbound 834	Cancellation

Change Reason Codes sent to the EB and CMOs due to the Merge Process:

Change Reason Code	834 Transaction Direction	Long Description
675	Outbound 834	Identifies the Change Reason Code for a Lock-in span Terminated on the Target Table Due to Merge Process

13.4 GF, MCHB and FCCMO Valid Values for Change Reason Codes/Assignment and Term Table - HD04 positions 15-18

Change Reason Codes in the 834 have three purposes:

1. Edit errors from inbound 834

Disenrollment Reason Code	Description
004	NO-PLANS-AVAIL (member not assigned to PMP)
022	INCOMPLETE PCP INFORMATION
028	WV – B6108-C-PROV-NOT-FND
200	INVALID RECORD TYPE (MISSING MEMBER ID)

Disenrollment Reason Code	Description
300	INVALID/MISSING MEMBER ID
305	INVALID ASSIGNMENT REASON CODE
306	INVALID CHANGE REASON CODE
310	MISSING REQUIRED RES ADDR FLDS
311	MISSING REQUIRED MLG ADDR FLDS
312	MBR TO DISENROLL NOT ENROLLED
314	INVALID LOCKIN DATES
318	INVALID ENROLL/DISENROLL TRANSFER PAIR
322	INVALID PROVIDER/PLAN
329	MBR NOT FND ON LOCKIN/PENDED
504	PROV NOT FOUND
510	PCP NPI MISSING
511	PCP MCD MISSING
512	PCP TAXPAYER ID MISSING
513	PCP ZIP CODE MISSING
514	PCP ZIP CODE MISMATCH

2. Disenrollment reason

   Outbound to inform the EB results from processing the daily 834 inbound and new potential.

Disenrollment Reason Code	Description
200	INVALID RECORD TYPE (MISSING MEMBER ID)
201	MEMBER ID NOT FOUND
300	INVALID/MISSING MEMBER ID
301	DUPLICATE ROW FOUND
302	COUNTY CODE NOT FOUND REGION
303	NAME NOT MATCHED
304	INVALID / UNMATCHED SSN

Disenrollment Reason Code	Description
305	INVALID ASSIGNMENT REASON CODE
306	INVALID CHANGE REASON CODE
307	PEND ROW ALREADY EXIST
308	INVALID RESIDENTIAL COUNTY
309	INVALID MAILING COUNTY
310	MISSING REQUIRED RES ADDR FLDS
311	MISSING REQUIRED MLG ADDR FLDS
312	MBR TO DISENROLL NOT ENROLLED
313	INVALID DEATH DATE
314	INVALID LOCKIN DATES
315	INVALID PLAN FOR THIS COUNTY
316	INVALID/MISSING CASE NUMBER
317	MBR ENROLLED TO SAME CMO
318	RE-ENROLL NOT AFTER DISENROLL
319	MISSING/INVALID REGION CODE
320	PROVIDER/PLAN ID NOT MATCHED
321	INVALID LOCKIN TYPE CODE
322	INVALID PROVIDER/PLAN
323	MBR PENDING EXEMPT PROGRAM
324	DUPLICATE PRIOR TRANSACTION
325	ENROLLMENT-FOR-CHOICE DROPPED
326	BACKOUT DISENROLL, ENROLL ERR
327	INVALID RES ADDR, MLG ADDR OK
328	INVALID MLG ADR, RES ADDR OK
329	MBR NOT FND ON LOCKIN/PENDED
330	LOCKIN DATE LESS THAN REGION START DATE
631	FC STOP FC-DJJ MOVING TO AA
633	FC STOP AA MOVING TO FC-DJJ
647	RECONCILIATION ADJUSTMENT STOP

Disenrollment Reason Code	Description
655	CMO MASS CHG TERM
675	MEMBER MERGE
676	MEMBER UNMERGE
677	CMO MORAL OR RELIGIOUS DSENRL
678	CMO MBR REQ SAME PLN AS FAMILY
679	CMO FOR CAUSE DISENROLLMENT
684	CMO REQ FOR POOR QLTY CARE
685	CMO REQ FOR SERV NOT PROVIDED
692	CMO FRAUD/ABUSE SVCS
693	CMO MEM CHOICE-YRLY OPN ENRL
695	MC YEARLY OPEN ENROLLMENT OVRD
696	CMO MASS CHANGE TERM LOW VALUE
697	CMO MASS CHANGE TERM CURR DATE
698	SPECIAL CHANGE DUE TO CMO EXIT
901	PLAN NOT VALID FOR RGN
902	NO PARENT ELIGIBILITY
903	AID CODE NOT ALLOWED FOR PLAN
905	MEMBER IN EXCLUDED BENEFIT PLN
906	MEMBER IN EXCL ASGN PLAN - GF
907	MEMBER IN EXCL ASGN PLAN - DSM
908	MEMBER IN EXCL ASGN PLAN - ASO
909	MEMBER IN EXCL ASGN PLAN -GBHC
911	MEMBER HAS EMA ELIGIBILITY
912	MEMBER HAS WAIVER - CCSP
913	MEMBER HAS WAIVER - CHMRP
915	MEMBER HAS WAIVER - CPNOW
916	MEMBER HAS WAIVER - ICWP
918	MEMBER HAS WAIVER - GAPP2
919	MEMBER HAS LOCKIN - GAPP1

Disenrollment Reason Code	Description
920	MEMBER HAS LOCKIN - ICFMR
921	MEMBER IN HOSPICE - LHSP
922	MEMBER IN NHOME
923	MEMBER IN SOURCE
924	MEMBER IN HOSPICE - TA90
925	MEMBER IN HOSPICE - TB90
926	MEMBER INHOSPICE - TC30
927	MEMBER IN HOSPICE - TD185
928	MEMBER IN HOSPICE - TX90
929	MEMBER IS DEAD
930	MEMBER IN FOSTER CARE LV ARNG
931	MEMBER HAS MEDICARE
932	MEMBER HAS HIPP
933	MEMBER HAS CMS EXEMPTION
934	MEMBER HAS NATIVE AMERICAN EXM
944	MEMBER IN EXCL ASGN PLAN - MCHB
948	MEMBER HAS TPL COVERAGE
956	MEMBER HAS TRIS EXEMPTION
957	MEMBER HAS C-BAY
959	MEMBER MOVED OUT OF PROV RGN
960	MEMBER ABUSIVE/DISRUPTIVE
962	MEMBER NON COMPLIANT
963	OTHER DISENROLLMENT REASON
967	MASS TRANSFER
968	MASS DISENROLLMENT
969	MEMBER HAS WAIVER - CONVERSION
970	FRAUD/ABUSE SERVICES
972	DCH AUTHORIZED EXEMPTION
974	MEMBER HAS GAPP1 OR GAPP2

Disenrollment Reason Code	Description
975	EXEMPTION CONDITION
979	MBR DOES NOT MEET PGM CRITERIA
985	MCHB INVALID AID CAT FOR GF OVERLAP
986	FC/AA/DJJ MOVING TO A NON-MC FFS
987	FC/AA/DJJ MOVING FROM FC TO SAME GF CMO
988	NO FC/AA/DJJ ELIGIBILITY
989	SSI CHILDREN NO LONGER IN CARE
990	AA-PROGRAM OPT OUT
991	MEMBER MOVING TO FC CMO
992	MEMBER IN EXCL ASGN PLAN - FC
993	MEMBER HAS ADOPTION ASSISTANCE EXEMPTION

3. Daily Inbound Disenrollments from the EB to GAMMIS

   Valid Values are:

Disenrollment Reason Code	Description
665	Special Disenrollment – Member Death
667	Special Disenrollment – Member Incarcerated
668	Special Disenrollment – Member Moved
669	Special Disenrollment – Member Medicare
674	Member Change during Open Enrollment Period
677	CMO MORAL OR RELIGIOUS DSENRL
678	CMO MBR REQ SAME PLN AS FAMILY
679	CMO FOR CAUSE DISENROLLMENT
684	CMO REQ FOR POOR QLTY CARE
685	CMO REQ FOR SERV NOT PROVIDED
945	Special Disenrollment – Member Pregnant
946	Special Disenrollment – Member Sterilized

13.5 GF and MCHB Assignments / Disenrollment's Pairs Sent by Enrollment Broker – HD04 positions 11-14 and 15-18

Assignments / Disenrollment's that must be sent by the Enrollment Broker in pairs:

TERM CODE	TERM DESCRIPTION	ASSGN CODE	ASSIGNMENT DESCRIPTION	CONDITION	ORIGIN
967	Mass Change termination with a corresponding reassignment	899	Mass Change Assignment	Member's assignment by the Mass Change process. Reassignment for 659 closure	HPES – to move all or part of a CMOs membership to one or more CMOs using a percentage or count.
674	Change of Plan Choice. Disenrollment during the 90 day choice period prior to being locked in to a CMO	652	Member Choice change	Change of (CMO) plan during the 90 day choice period prior to being locked into a plan. Note: See 90 Day Transfer Special Processing.	EB – Daily Member choice changes
677	GF Member Request moral or religious reasons	657	GF Member reassignment for moral or religious reasons	Member request disenrollment from plan due to plan not providing services because of moral or religious reasons. Reassignment for 677 closure.	EB
678	GF Member Request same plan as family	658	GF Member reassignment to same plan as family	Member request disenrollment from plan to be in same plan as family member. Reassignment for 678 closure.	EB

TERM CODE	TERM DESCRIPTION	ASSGN CODE	ASSIGNMENT DESCRIPTION	CONDITION	ORIGIN
684	GF Member Request due to poor quality of care	660	GF Member reassignment due to poor quality of care	Member request disenrollment from plan due to poor quality of care, lack of access, lack of provider experience with certain needs. Reassignment for 684 closure.	EB
685	GF Member Request due to service not provided	662	GF Member reassignment due to service not provided	Member request due to related services not provided. Reassignment for 685 closure.	EB
693	Member's new choice during yearly open enrollment period	663	Member's new choice during yearly open enrollment period	Member request change of CMO during his/her annual open enrollment period.	EB
695	Member's new choice during yearly open enrollment period – Adjusted	671	Member's new choice during yearly open enrollment period – Adjusted	Member request change of CMO during his/her annual open enrollment period, adjusted or deferred to subsequent month.	EB

NOTE: 90 Day Transfer Special Processing

A 90 day transfer is only valid if the active assignment has an Effective Date within 90 days prior to the current processing date and has one of these Assignment Codes:

- 650 CMO Auto assign-no select

- 651 CMO auto assign-selection
- 656 CMO infant enroll
- 658 CMO reassign to same family plan
- 661 CMO historic enrollment
- 672 CMO Pregnant or WHM - no selection
- 673 CMO Pregnant or WHM - selection
- 681 CMO Pregnant or WHM - assign to same family plan
- 682 CMO Pregnant or WHM - historic enrollment
- 711 CMO PEACHCARE FOR KIDS-NO SELECTION
- 712 CMO PEACHCARE FOR KIDS-SELECTION
- 713 CMO PEACHCARE FOR KIDS-ASSIGN SAME FAMILY
- 714 CMO PEACHCARE FOR KIDS-ASSIGN HISTORIC

And the respective Mxxx merge code for each. If an Assignment Code 694 CMO member reassigned is found that is due to a region change, then the Assignment Code and Effective Date of the latest assignment prior to the region change is checked.

13.6 GF and MCHB Valid Values for Response Codes – Daily and Monthly - HD04 position 34

On the Daily, Monthly Roster and Monthly Variance outbound transactions, the Response Code field indicates the source of the addresses in the 2100A (Residence address) and 2100C (Mailing address). Preference is given to any vendor specified address for the member. The Response Code field is sent on the outbound 834 transactions, and is not required or used on inbound 834 transactions.

Response Code	Description
1	Both address for record of source
2	Mailing from vendor, Residence from record of source
3	Mailing from record of source, Residence from vendor
4	Both address from vendor

13.7 Response Code - HD04 position 34 – Quarterly GF and MCHB

On the Quarterly Reconciliation outbound transactions, the Response Code field indicates result of the reconciliation process. The Response Code field is sent on the outbound 834 transactions, and is not required or used on inbound 834 transactions.

Reconciliation records that pass preprocessing (P) or match on compare (5) will not be sent back in the outbound 834. The response codes P and 5 will be retained for reporting of Passed Preprocessing and Match Records, respectively.

Response Code	Description
1	Invalid member ID
2	Invalid Enrollment Period
3	Duplicate Record on Inbound File
4	Duplicate Record due to Member Merge
5	Matched Record – no longer sent
6	Potential Delete Record
7	Potential Add Record
C	Invalid Provider
P	Passed Preprocessing Only - no longer sent

13.8 Co Pay Required - HD04 position 35 –GF and MCHB

The Co Pay Required field will only contain a “Y” / “N” value for certain outbound transaction types, for all others it will be blank.

If the Co Pay Required field contains a value on the inbound record, it will be ignored.

Co-Pay Required Indicator	Description
Y	834 files sent to CMOs GF Assignments with PCK Eligibility that are not excluded from Co-Pay One of these transactions: Monthly Roster – New Member on Roster (021/09) Monthly Roster – Current Member on Roster (030/10) Monthly Audit – Current Member on Roster (030/10) Daily – Enrolled Newborn (021/14)

Co-Pay Required Indicator	Description
	Daily – Online Update-Change (030/27)
N	834 files sent to CMOs GF Assignments with PCK Eligibility that are excluded from Co-Pay One of these transactions: Monthly Roster – New Member on Roster (021/09) Monthly Roster – Current Member on Roster (030/10) Monthly Audit – Current Member on Roster (030/10) Daily – Enrolled Newborn (021/14) Daily – Online Update-Change (030/27)
Blank	Any of these conditions would cause a blank indicator to be sent in this field: 834 files sent to Enrollment Broker (EB) Assignments with non-PCK Eligibility Any transaction other than these: Monthly Roster – New Member on Roster (021/09) Monthly Roster – Current Member on Roster (030/10) Monthly Audit – Current Member on Roster (030/10) Daily – Enrolled Newborn (021/14) Daily – Online Update-Change (030/27)

14 Appendices (Aid Categories)

14.1 Aid Categories for GF

Below is a list of CMO Eligible Aid Categories that will include members into the GF program. The member needs to have an aid category that is in the inclusion table, not be excluded for any reason and pass all the eligibility checks to be deemed eligible for the CMO.

Cohort	Age	Sex	Category	Related Category of Eligibility
401	18-44	Female	P4HB	180 P4HB Inter Pregnancy Care
402	18-44	Female	P4HB	181 P4HB Family Planning Only

Cohort	Age	Sex	Category	Related Category of Eligibility
403	18-44	Female	P4HB	182 P4HB ROMC - LIM 183 P4HB ROMC - ABD
502 503 504 505 506	FC/DJJ 0-5 years AA 6-10 years AA 11-17 years AA 18+ years AA	n/a	Foster Care, Department of Juvenile Justice, Adoptive Assistance	131 Child Welfare Foster Care 132 State Funded Adoption Assistnce 133 Foster Care IV-E 134 Adopt Asssit IV-E 137 PCK/MA Foster Care 138 PCK/MA DJJ 150 Department of Juvenile Justice 151 CHAFFEE Medicaid 152 Former Foster Care Children 153 Waiver child with a Foster Care placement 794 360 Peach 101-150% FPL 795 360 Peach 151-200% FPL 796 360 Peach 201-247% FPL 797 360 Peach >247% FPL
601 602 603 604 605 606 607 608	0-2 months 3-11 months 1-5 years 6-13 years 14-20 years 14-20 years 21-44 years 21-44 years	n/a n/a n/a n/a Female Male Female Male	LIM/RSM/Refugee	104 LIM - Adult 105 LIM - Child 118 LIM-1st Yr Trans Med Ast Adult 119 LIM-1st Yr Trans Med Ast Child 120 LIM-2nd Yr Trans Med Ast Adult 121 LIM-2nd Yr Trans Med Ast Child 122 CS Adult 4 Month Extended 123 CS Child 4 Month Extended 124 Standard Filing Unit - Adult 125 Standard Filing Unit - Child 126 Stepchild 135 Newborn Child 136 PCK/MA 152 Former Foster Care Children 170 RSM Pregnant Woman

Cohort	Age	Sex	Category	Related Category of Eligibility
				171 RSM Child
609	45 years and older	Female		194 RSM Expansion Pregnant Woman
				195 RSM Expansion Child < 1 Yr
				196 RSM Expn Chld w/ DOB <=10/1/83
610	45 years and older	Male		197 RSM Preg Women Income>185 FPL
				471 RSM Child
620	6-13 years	n/a		506 Refugee (DMP) - Adult
				507 Refugee (DMP) - Child
621	14-18 years	Female		508 Post Ref Extended Med - Adult
				509 Post Ref Extended Med - Child
622	14-18 years	Male		510 Refugee MAO - Adult
				511 Refugee MAO - Child
				571 Refugee RSM Child
				595 Refugee RSM Exp. Chld <1
				596 Ref.RSM Exp. Chld DOB </=100183
				804 Lim REI Adult
				805 Lim REI Child
				818 TMA REI Adult
				819 TMA REI Child
				835 Newborn
				836 Newborn (DFACS)
				871 RSM (DHACS)
				872 RSM 150% Expansion (DHACS)
				876 RSM Preg Woman (DHACS)
				894 RSM Exp. Preg Woman (DHACS)
				895 RSM Exp. Chld. <1 (DHACS)
				896 RSM Exp. Chld. </=10183(DHACS)
				897 RSM Preg Wom Inc>185%FPL(DHACS
				898 RSM Child<1 Moth Aid= 897(DHAC
				918 LIM Adult
				919 LIM Child

Cohort	Age	Sex	Category	Related Category of Eligibility
				920 Refugee Adult 921 Refugee Child
611 612 613 614 615 616	0-2 months 3-11 months 1-5 years 6-13 years 14-20 years 14-20 years	n/a n/a n/a n/a Female Male	PeachCare	790 Peachcare <150% FPL 791 Peachcare 150 - 200% FPL 792 Peachcare 201 - 235% FPL 793 Peachcare >235% FPL
617	n/a	n/a	Breast and Cervical Cancer	245 BCC Waiver 800 Presumptive BCC
618	n/a	n/a	Delivery Payment	'DVP' may appear in this field. This is not a COE code. This is the indicator for delivery payment.

14.2 Aid Categories for PCK

COE	AID CATEGORY DESCRIPTION
790	Income < = 150,000
791	Income > 150,000 but < = 200,00
792	Income > 200,000 but < = 235,000
793	Income > 235,000

14.3 Aid Categories for P4HB / MCHB

COE	AID CATEGORY DESCRIPTION
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only

COE	AID CATEGORY DESCRIPTION
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD

14.4 Aid Categories for FCCMO (GF360)

COE	AID CATEGORY DESCRIPTION
131	Child Welfare Foster Care
132	State Funded Adoption Assistnce
133	Foster Care IV-E
134	Adopt Asssit IV-E
137	PCK/MA Foster Care
138	PCK/MA DJJ
150	Department of Juvenile Justice
151	CHAFFEE Medicaid
152	Former Foster Care Children
153	Waiver child with a Foster Care placement
154	Waiver child with a Department of Juvenile Justice placement
155	Waiver child with an Adoption Assistance placement
156	Waiver child that has lost Foster Care placement
157	Waiver child that has lost Department of Juvenile Justice placement
794	360 Peach 101-150% FPL
795	360 Peach 151-200% FPL
796	360 Peach 201-247% FPL
797	360 Peach >247% FPL
924	Foster Care
931	Child Welfare Foster Care

15 Appendices (County/Region Codes)

15.1 County Codes and Service Region

Values for Service Region Number, Region Name, County, County Code, and Region Code:

COUNTY	COUNTY CODE	CMO REGION / NAME
Appling	001	05 - Southeast
Atkinson	002	06 – Southwest
Bacon	003	05 - Southeast
Baker	004	06 - Southwest
Baldwin	005	02 - Central
Banks	006	04 - North
Barrow	007	01 - Atlanta
Bartow	008	01 - Atlanta
Ben Hill	009	06 - Southwest
Berrien	010	06 - Southwest
Bibb	011	02 - Central
Bleckley	012	02 - Central
Brantley	013	05 - Southeast
Brooks	014	06 - Southwest
Bryan	015	05 - Southeast
Bullock	016	05 - Southeast
Burke	017	03 - East
Butts	018	01 - Atlanta
Calhoun	019	06 - Southwest
Camden	020	05 - Southeast
Candler	021	05 - Southeast
Carroll	022	01 - Atlanta
Catoosa	023	04 - North
Charlton	024	05 - Southeast

COUNTY	COUNTY CODE	CMO REGION / NAME
Chatham	025	05 - Southeast
Chattahoochee	026	02 - Central
Chattooga	027	04 - North
Cherokee	028	01 - Atlanta
Clarke	029	04 - North
Clay	030	06 - Southwest
Clayton	031	01 - Atlanta
Clinch	032	06 - Southwest
Cobb	033	01 - Atlanta
Coffee	034	06 - Southwest
Colquitt	035	06 - Southwest
Columbia	036	03 - East
Cook	037	06 - Southwest
Coweta	038	01 - Atlanta
Crawford	039	02 - Central
Crisp	040	02 - Central
Dade	041	04 - North
Dawson	042	04 - North
Decatur	043	06 - Southwest
DeKalb	044	01 - Atlanta
Dodge	045	02 - Central
Dooly	046	02 - Central
Dougherty	047	06 - Southwest
Douglas	048	01 - Atlanta
Early	049	06 - Southwest
Echols	050	06 - Southwest
Effingham	051	05 - Southeast
Elbert	052	04 - North
Emanuel	053	03 - East
Evans	054	05 - Southeast

COUNTY	COUNTY CODE	CMO REGION / NAME
Fannin	055	04 - North
Fayette	056	01 - Atlanta
Floyd	057	04 - North
Forsyth	058	01 - Atlanta
Franklin	059	04 - North
Fulton	060	01 - Atlanta
Gilmer	061	04 - North
Glascock	062	03 - East
Glynn	063	05 - Southeast
Gordon	064	04 - North
Grady	065	06 - Southwest
Greene	066	03 - East
Gwinnett	067	01 - Atlanta
Habersham	068	04 - North
Hall	069	04 - North
Hancock	070	03 - East
Haralson	071	01 - Atlanta
Harris	072	02 - Central
Hart	073	04 - North
Heard	074	02 - Central
Henry	075	01 - Atlanta
Houston	076	02 - Central
Irwin	077	06 - Southwest
Jackson	078	04 - North
Jasper	079	01 - Atlanta
Jeff Davis	080	05 - Southeast
Jefferson	081	03 - East
Jenkins	082	03 - East
Johnson	083	02 - Central
Jones	084	02 - Central

COUNTY	COUNTY CODE	CMO REGION / NAME
Lamar	085	02 - Central
Lanier	086	06 - Southwest
Laurens	087	02 - Central
Lee	088	06 - Southwest
Liberty	089	05 - Southeast
Lincoln	090	03 - East
Long	091	05 - Southeast
Lowndes	092	06 - Southwest
Lumpkin	093	04 - North
Macon	094	02 - Central
Madison	095	04 - North
Marion	096	02 - Central
McDuffie	097	03 - East
McIntosh	098	05 - Southeast
Meriwether	099	02 - Central
Miller	100	06 - Southwest
Mitchell	101	06 - Southwest
Monroe	102	02 - Central
Montgomery	103	05 - Southeast
Morgan	104	04 - North
Murray	105	04 - North
Muscogee	106	02 - Central
Newton	107	01 - Atlanta
Oconee	108	04 - North
Oglethorpe	109	04 - North
Paulding	110	01 - Atlanta
Peach	111	02 - Central
Pickens	112	01 - Atlanta
Pierce	113	05 - Southeast
Pike	114	02 - Central

COUNTY	COUNTY CODE	CMO REGION / NAME
Polk	115	04 - North
Pulaski	116	02 - Central
Putnam	117	03 - East
Quitman	118	06 - Southwest
Rabun	119	04 - North
Randolph	120	06 - Southwest
Richmond	121	03 - East
Rockdale	122	01 - Atlanta
Schley	123	06 - Southwest
Screven	124	05 - Southeast
Seminole	125	06 - Southwest
Spalding	126	01 - Atlanta
Stephens	127	04 - North
Stewart	128	06 - Southwest
Sumter	129	06 - Southwest
Talbot	130	02 - Central
Taliaferro	131	03 - East
Tattnall	132	05 - Southeast
Taylor	133	02 - Central
Telfair	134	02 - Central
Terrell	135	06 - Southwest
Thomas	136	06 - Southwest
Tift	137	06 - Southwest
Toombs	138	05 - Southeast
Towns	139	04 - North
Treutlen	140	02 - Central
Troup	141	02 - Central
Turner	142	06 - Southwest
Twiggs	143	02 - Central
Union	144	04 - North

COUNTY	COUNTY CODE	CMO REGION / NAME
Upson	145	02 - Central
Walker	146	04 - North
Walton	147	01 - Atlanta
Ware	148	05 - Southeast
Warren	149	03 - East
Washington	150	03 - East
Wayne	151	05 - Southeast
Webster	152	06 - Southwest
Wheeler	153	02 - Central
White	154	04 - North
Whitfield	155	04 - North
Wilcox	156	02 - Central
Wilkes	157	03 - East
Wilkinson	158	02 - Central
Worth	159	06 - Southwest

16 Appendices (PCK Term Reason Codes)

16.1 PCK Term Reason Codes

Only required if terminating an Aid Category:

PLAN AID TERM REASON	DESCRIPTION
CCC	PCK PROC DEFAULT CLOSURE CODE
PRE	PCK RECON AUTO CLOSURE REASON
Z01	PCARE NON-PREMIUM PAYMENT
Z02	PCARE EMPLOYED BY STATE OF GA
Z03	PCARE INCOME EXCEEDS REQUIREMENT
Z04	PCARE OTHER INSURANCE
Z05	PCARE CHILD NOT IN PARENTS HOME

PLAN AID TERM REASON	DESCRIPTION
Z06	PCARE PARENT REQ CAN CHILD
Z07	PCARE NO SSN OR PROOF OF APPL
Z08	PCARE HAS MEDICAID COVERAGE
Z09	PCARE TEEN TURNED 19 YEARS OLD
Z10	PCARE CHILD TURNS 6 YEARS OLD
Z11	PCARE CHILD TURNS 1 YEARS OLD
Z12	PCARE FAIL TO PROVID SIGNATURE
Z13	PCARE CHILD MOVED OUT OF STATE
Z14	PCARE CHILD NOT A CITIZEN
Z15	PCARE NO LONGER PREGNANT
Z16	PCK CAN'T MAKE CONTACT WITH FAMILY
Z20	PCK CATEGORY OF AID CHANGED
SPACES	AID CATEGORY (COE) IS NOT TERMINATED

17 Appendices (DTP Matrix)

17.1 2000 and 2300-DTP Matrix

Below is a matrix for the HD01 (Maintenance Type Code), Record Type Code, 2000-DTP Segment, where DTP01=356 (Eligibility Begin), DTP01=357 (Eligibility End), DTP01=303 (Benefit Maintenance), 2300-DTP01=348 (Benefit Begin), DTP01=349 (Benefit End) and Description:

HD01 (Maintenance Type Code)	**Record Type Code REF02, where REF01= 3H**	**Eligibility Begin 2000 DTP01=356**	**Eligibility End 2000 DTP01=357**	**Benefit Maintenance 2300 DTP01=303**	**Benefit Begin 2300 DTP01=348**	**Benefit End 2300 DTP01=349**	**Description**
021	01	Yes	Yes	No	Yes	No	Potential Eligible (No Assignment)
001	04	Yes	Yes	Yes	No	No	Demographic Change

HD01 (Maintenance Type Code)	Record Type Code REF02, where REF01= 3H	Eligibility Begin 2000 DTP01=356	Eligibility End 2000 DTP01=357	Benefit Maintenance 2300 DTP01=303	Benefit Begin 2300 DTP01=348	Benefit End 2300 DTP01=349	Description
001	06	Yes	Yes	Yes	Yes	No	Ineligible
030	07	Yes	Yes	Yes	No	No	Merge Source
030	08	Yes	No	No	Yes	Yes	Merge Target
021	09	Yes	No	No	Yes	Yes	New Member on Roster
030	10	Yes	No	No	Yes	Yes	Current Member
024	11	Yes	No	No	Yes	Yes	Terminated
001	12	Yes	No	No	Yes	Yes	Retroactive
021	13	Yes	Yes	No	Yes	No	Pended Member on Roster
021	14	Yes	No	No	Yes	Yes	Enrolled Newborns
030	15	Yes	Yes	No	Yes	No	Member in Foster Care
001	16	No	No	No	Yes	No	PCP Change
001	17	No	No	Yes	No	No	Member Change
024	18	Yes	No	No	Yes	Yes	Void CMO Lockin Span
030	21	Yes	Yes	No	Yes	No	Transition to GAPP
030	22	Yes	Yes	No	Yes	No	Transition to Deeming
030	23	Yes	Yes	No	Yes	No	Transition to CMS
030	24	Yes	Yes	No	Yes	No	Transition to SSI

HD01 (Maintenance Type Code)	Record Type Code REF02, where REF01= 3H	Eligibility Begin 2000 DTP01=356	Eligibility End 2000 DTP01=357	Benefit Maintenance 2300 DTP01=303	Benefit Begin 2300 DTP01=348	Benefit End 2300 DTP01=349	Description
030	25	Yes	Yes	No	Yes	No	Transition to Hospice
024	27	Yes	No	No	Yes	Yes	Online Update – Termination
030	27	Yes	No	No	Yes	Yes	Online Update – Change
021	28	Yes	No	No	Yes	Yes	GF Enroll Immediate – WHM or Pregnancy
021	29	Yes	No	No	Yes	Yes	MCHB Enroll Immediate
024	30	Yes	No	No	Yes	Yes	FCCMO Disenroll Immediate
021	31	Yes	No	No	Yes	Yes	FCCMO Enroll Immediate
024	32	Yes	No	No	Yes	Yes	GF Disenroll Immediate
021	33	Yes	No	No	Yes	Yes	GF Enroll Immediate
021	34	Yes	No	No	Yes	Yes	GF Enroll Immediate - PCK
024	92	Yes	No	No	No	Yes	Dis-enroll Fail
021	93	Yes	Yes	No	Yes	No	Enroll Fail

18 Appendices (Other)

18.1 Implementation Checklist

This appendix contains all necessary steps for going live with Georgia Medicaid.

1. Call the HP Enterprise Services EDI Services Team with any questions at the Toll Free Number.
2. Check the Georgia Web Portal http://www.mmis.georgia.gov regularly for the latest updates.
3. Confirm you have completed your TPA Agreement and been assigned a Trading Partner ID.
4. Make the appropriate changes to your systems/business processes to support the updated companion guides:
    - If you use third party software, work with your software vendor to have the appropriate software installed.
    - If testing system-to-system (Real-Time) interface the Trading Partner or provider must work with your software vendor to have the appropriate software installed at their sites(s) prior to performing testing with Georgia Medicaid.
5. Identify the transactions you will be testing:
    - Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
    - Health Care Claim Status Request and Response (276/277)
    - Health Care Premium Payment (820)
    - Health Care Benefit Enrollment and Maintenance (834)
    - Health Care Payment/Advice (835)
    - Health Care Claim: Dental (837D)
    - Health Care Claim: Institutional (837D)
    - Health Care Claim: Professional (837P)
6. Confirm you have reported all the NPIs you will be using for testing by validating them with Georgia Medicaid. Make sure your claim(s) successfully pay to your correct Provider ID, if you have associated multiple Georgia Medicaid provider IDs to one NPI and/or taxonomy code.
    - If the entity testing is a billing intermediary or software vendor, they should use the provider's identifiers on the test transaction.
7. When submitting test files, make sure the members/claims you submit are representative of the type of service(s) you provide to Georgia Medicaid members.
8. Schedule a tentative week for the initial test.
9. Confirm the email/phone number of the testing contact and confirm that the person you are speaking with is the primary contact for testing purposes.

18.2 Transmission Example

This is an example of a batch file that contains one (1) member. For Georgia Medicaid batch files have the ability to loop at the functional group, transaction and hierarchical levels. Each functional group within an interchange has to be the same transaction type.

ISA*00* *00* *ZZ*TPID *ZZ*77034 *130402*0800*^*00501*505043666*0
T:~
GS*BE*TPID*77034*20130402*051429*0001*X*005010X220A1~
ST*834*000000001*005010X220A1~
BGN*00*0001*20130402*051319*ES***2~
REF*38*GAPROVID9~
N1*P5*GEORGIA FAMILIES*FI*06-TAXID11~
N1*IN*INSURERNAME*FI*12-TAXID12~
INS*Y*18*001**A***FT~
REF*0F*MEMBERID1234~
REF*1L*MEMBERID1234~
REF*ZZ*791P N000000000000~
REF*3H*CASENUMBER 16~
NM1*IL*1*MEMLNAME*MEMFNAME****34*SSN111111~
PER*IP**TE*4041234567~
N3*1333 MEMBER ADDRESS~
N4*ATLANTA*GA*303154401**CY*060~
DMG*D8*20101026*M**H~
HD*001**HMO*CMO 010001 0000000000000000000*IND~
DTP*348*D8*20121201~
DTP*349*D8*22991231~
LX*1~
NM1*Y2*2******SV*PROVIDERID*25~
N4*ATLANTA*GA*303462487~
LX*2~
NM1*P3*2******XX*NPIID12345*25~
N4*ATLANTA*GA*303153016~
SE*25*000000001~
GE*1*0001~
IEA*1*505043666~

18.3 Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to Georgia Medicaid and its providers.

Q: As a trading partner or clearinghouse, who should I contact if I have questions about testing, specifications, trading partner enrollment or if I need technical assistance with electronic submission?

A: EDI testing and trading partner enrollment support is available Monday through Friday 8a.m.-5p.m. by calling toll-free at (877) 261-8785 or locally at (770) 325-9590.

Q: Who should I contact if I have questions pertaining to billing or to check on the status of a submitted claim?

A: Providers should contact the Provider Contact Center for any non-EDI related questions or GAMMIS Web Portal assistance by calling the Interactive Voice Response System (IVRS) toll-free at (800) 766-4456 or locally at (770) 325-9600.

Q: After I submit my EDI Trading Partner Agreement Form, when should I expect to receive my Trading Partner ID?

A: Once we receive your EDI enrollment in the mail and process it, which takes 1-5 days, you should receive your trading partner Web Portal logon credentials by e-mail immediately. You will also receive your EDI Welcome Letter by mail within 5-7 business days of your application being approved. If your trading partner logon credentials were not received, contact EDI Services Monday-Friday 8a.m.-5p.m. EST at (877) 261-8785 or locally at (770) 325-9590, or submit a Contact Us Inquiry on the GAMMIS Web Portal. For authentication purposes, please be prepared with your Trading Partner Name, Trading Partner ID assigned, and Mailing Address.

Q: What are the steps that Providers need to take to begin sending EDI Transactions and testing with HP Enterprise Services?

A: All providers must already be enrolled with Georgia Medicaid to apply for EDI Enrollment, unless using a clearinghouse, software vendor, or billing agent. However, providers may also enroll as direct electronic submitters using the EDI Trading Partner Agreement. A copy of the EDI Agreement can be downloaded from the GAMMIS Web Portal on the EDI >> Registration Forms page. Once approved to send EDI transactions, all providers/submitters (except those using an enrolled clearinghouse, software vendor, or billing agent) will be required to go through testing using their chosen EDI software, clearinghouse, or vendor. Testing is not required for use of the PES software. Providers can contact EDI Services toll-free at (877) 261-8785 or locally at (770) 325-9590 for additional details regarding EDI transactions, testing, and PES training. Providers can begin testing files in Ramp Manager immediately. Once testing is passed, providers should submit the necessary EDI trading partner agreement (if enrolling for the first time) or the EDI Update form (if making a change to their transaction) to be made active in Production.

Q: How do I access Ramp Manager to test my transactions?

A: You can access Ramp Manager online by visiting the Georgia Health Partnership Ramp Management System at https://sites.edifecs.com/index.jsp?gamedicaid.

Q: Is there a certain number of test files that need to be sent through Ramp Manager?

A: No; however, HP Enterprise Services requires a test file to pass compliance for each transaction type and trading partner that will be sending files. The status of each transaction should show "PASS" in Ramp Manager to show that you have successfully passed compliance before HP Enterprise Services can make you active.

Q: I am a provider. How do I enroll to receive my Remittance Advice electronically (835-ERA)?

A: Providers must complete and submit an HP Submitter Update Form indicating that they would like to receive an ERA835 for the payee ID. If you wish to delegate access to these 835 ERAs (Electronic Remittance Advice) so that your clearinghouse, software vendor, or billing agent can access these on your behalf, you must provide them access to your file downloads. Contact your clearinghouse, software vendor, or billing agent to get the e-mail address and username that you should grant access to, then follow the instructions in the GAMMIS Web Portal User Account Management Guide on the Provider Information >> Provider Manuals page. Refer to section 3.2, titled "Providers or Trading Partners Delegating Access to a Billing Agent or Trading Partner Account" for detailed instructions. You will need to grant the "Trade Files Download" role for a user to have access to your 835 ERA file.

Q: After I submit my provider enrollment application, when should I expect to receive my PIN letter in the mail?

A: You should receive your PIN letter within 5-7 business days of your Provider Enrollment application being approved. If you do not receive your PIN letter within this timeframe, please contact EDI Services Monday-Friday 8am-5pm EST at (877) 261-8785 or locally at (770) 325-9590, or submit a Contact Us Inquiry on the GAMMIS Web Portal. For authentication purposes, please be prepared with the provider's account information: provider's Name, provider ID, Tax ID/SSN, and the Mailing Address.

Q: Where is my PIN letter being sent?

A: PIN letters are sent to the provider's mailing address on file. If the mailing address shown on file is incorrect, providers must submit the Medicaid Change of Information form (as shown on the GAMMIS Web Portal under the Provider Information >> Provider Manuals page) to ensure the address is up–to-date before the PIN letter reissue request can be processed.

Q: How do I request and submit EDI files through the Web Portal?

A: Establish an internet connection to the provider secure Web Portal using your trading partner account logon credentials. Select the Trade Files menu in order to download and/or upload EDI files.

- **File Upload**
  The File Upload page allows the user to select a file from a local hard drive and upload it to the Georgia MMIS. The file extension should end in .txt. Users of the feature include clearinghouses, software vendors, third party agents, and providers that wish to upload batch EDI transactions directly, including claim and encounter submissions. To use the batch upload option, providers must use HIPAA-compliant software or vendors that can create required data in HIPAA-compliant ANSI X12 Addenda format.

- **File Download**
  The File Download page allows the user to select a file from the secure GAMMIS Web Portal and download it to their system. The download process begins when the download option is checked and the user selects the download button.

Q: How long are ERA835, 277U, 824, and/or 999's available for download on the GAMMIS Web Portal?

A: All outbound EDI transactions will be made available for download on the provider portal for six weeks from the date of creation. Providers and trading partners are encouraged to download the documents as soon as they are available.

Q: What types of acknowledgment reports will HP return following EDI submission?

A: A TA1 will be generated when errors occur within the interchange envelope ISA/IEA. If no TA1 is generated, by default an 824 Acknowledgment is returned to the trading partner for all 837P, 837I, and 837D claim transaction types. A 999 acknowledgement will be returned on batch 270 (Eligibility) and 276 (Claim Status) and failed 270 Real-Time (Eligibility Requests) and 276 Real-Time (Claim Status) transaction types. For those real-time 270 and 276 transactions that pass compliance, the respective 271 and 277 transactions will be generated. A 999 acknowledgement will be returned on batch 834 (Benefit Enrollment) transactions. The 835 (ERA) will be returned to the payee provider or trading partner delegated by the provider if the claims were accepted electronically and forwarded for claims adjudication. The 277U (Unsolicited Claim Status Report) is returned if there was a problem with the claims that prevented the claims adjudication system from processing the claims (for example, Invalid NPI or Provider Not on File).

Q: Will electronic remittances (835) be returned in one file for all providers or a separate file for each provider?

A: There will be separate files for each provider.

Q: Will our trading partner number or submitter ID, as shown in the ISA06, be returned in the remittance advice 835 file?

A: No, the ISA08 and GS03 within the remittance advice 835 will contain the Payee Provider ID.

Q: What filename will be used for the 835 files?

A: As documented in the 835 companion guides, the filename will be in this format: BatchID_TransactionType_FileName_ProviderNumber_Sequence Number_ProcessDate.out.dat.

Q: Will HP Enterprise Services continue to send paper EOBs for providers that are receiving the Electronic Remittance Advice (ERA)?

A: No, unless specifically requested by the provider to receive both. Providers can notify EDI Services or the Provider Enrollment Unit if they wish to receive both the paper EOB and the ERA.

Q: Where can we find the Georgia Medicaid/PeachCare for Kids® HIPAA Companion Guides?

A: The companion guides are available on the Web Portal on the EDI >> Companion Guides page.

Q: Where can I find a copy of the HIPAA ANSI TR3 Implementation Guides?

A: The TR3 Implementation Guides must be purchased from the Washington Publishing Company at www.wpc-edi.com.

19 Change Summary

This section describes the differences between the current Companion Guide and previous guides(s).

Version	Date	Section/Pages	Descriptions
1.15	04/04/2013	Entire document	Complete revision to comply with CAQH® (Council for Affordable Quality Healthcare) CORE™ (Committee on Operating Rules for Information Exchange) v5010 Master Companion Guide Template. Transaction specific data elements, and their values, were not changed. All previous versions are obsolete.
2.0	4/29/2013	Logo on Cover Page Entire Document	Changed Logo on Cover Page to be the new branding logo. Changed any reference to TR3 to be TR3 Implementation Guide or Implementation Guides. Changed references to companion guide that were listed as 'document' to 'companion guide'. Changed any reference from 997 to 999. Changed Section 9.2 from 997 to 999 information.
2.1	2/10/2014	Entire Document	Changed references from GF and MCHB to GF, MCHB and FCCMO. Changed VV is the vendor code from "ag", "ps" or "wc" to "ag", "ps", "wc" or "af". Section 7.1: Added 'and NM108=SV after 'where NM101=Y2' within first paragraph. Section 8: Modified to include FCCMO information. Section 11.1: Added Plan Sponsor Name information for FCCMO. Major Program Code (REF02): Added 'F' FosterCare. County of Custody and Eligibility End

			Date for FCCMO. 2100G: NM103-NM105, NM107 – Added Outbound FCCMO information. HD01: Removed Inbound/Outbound: GF/MCHB from Notes/Comments. HD04: Changed Months Enrolled (A/N) to Open Enrollment Month/Day (MMDD). 2310-NM1: Added Primary Care Dentist. Section 12.1: Added Codes 32/33. Section 12.3 (Added), which caused renumbering of current Section 12.3-12.9. Section 13.2: Added Codes 994, 996-998. Section 13.4 #2: Added Code 948, 986-993 Section 14.1: Added Related Category of Eligibility Code of 152 for Cohort Code 607 Section 14.1: Added Cap Categories/Aid Category, See Cohort 502-506. Section 14.4: Added Aid Categories for FCCMO. Section 17.1: Added Record Type Code 30-33 Information.
2.2	4/25/2014	Section 13	Section 13.2: Add Assign Reason 671. Add clarification to Assign Reason 694. Section 13.4: Modify Description of 318 Section 13.5: Modify Override Code from 695/694 to 695/671.
2.3	11/21/2014	Sections 13 and 17	Section 13.2 and 13.5: Add Assign Reason 672, 673, 681 and 682. Section 17: Add record types 28 and 29. Section 7.9: Added.
2.4	2/2/2015		Overall correction made: Moved value of '29' from section 12.1 to 12.2.

Modifications made for CSR 904:
Section 14.1: Added Related Category of Eligibility values '137-138'.
Added Cohort values of 620-622 and associated Age/Sex column information. Also added value of '136' to Related Category of Eligibility' column.
Section 14.4: Added (GF360) to heading. Added values of '137' and '138' along with Description.

Modifications made for CSR 871:
Section 12.1: Added '34'.
Section 13.2, #1: Added '711'.
Section 13.2, #2: Added '711-715'.
Section 13.5: Added '711-714'.
Section 14.1: Added '794-797'.
Section14.1: Removed '154-157', '924' and '931'.
Section 14.4: Added '794-797'.
Section 17.1: Added '021' – GF Enroll Immediate – PCK.

Modifications made for CSR 997:
Updated 2100A-PER01-PER06
Added 2100A-PER07-PER08.