Michigan Medicaid

Health Care Eligibility Benefit Inquiry and Response (270/271)

ASC X12N 005010X279A1

Refers to the Implementation Guides
Based on ASC X12 version 005010

MPHI Companion Guide for 5010

EDITOR'S NOTE:
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Document Revisions

Version	Date	Section	Explanation of Revision
1.85	2024/8/15	All	Removed Transaction Examples, updated links, removed MIChild section
1.7	2019/08/30	5	Updated support information and contact details
1.6	2018/01/25	Multiple	Changed all references from https://public.mphi.org/sites/eligibility/Pages/default.aspx to https://hpb.mihealth.org/v2/public
1.5	2016/01/01	7.8	Removed the MIChild lookup information and created a new section (7.8) to explain how to retrieve MIChild information prior to Jan. 1, 2016.
1.4	2015/08/07	Multiple 10.5	Changed all references from DCH to DHHS Removed Medicaid Redetermination Date section (Formerly Section 7.4) Added Section 10.5 Benefit Plan ID Codes
1.3	2014/06/11	All	Rewrote major parts of the guide.
1.2	2012/06/22	5.2 7.1 7.8 8.1 8.2	Replaced contact for Web-Service Support Updated Search Criteria to include Identification Card Serial Number Added section to describe card track layout of MIHealth card Added GH code to REF segments
1.1	2012/04/20	4.2 4.4.4 4.5.4 7.1 7.2 7.3 8.1	Corrected reference to Retransmission Guidelines Increased timeout period to 60 seconds Increased timeout period to 60 seconds Corrected 2100A_NM109 values for Medicaid and MI Child Inquiries Changed date range limit to 3 months Corrected EQ segment in example Corrected reference to Beneficiary Search Criteria Corrected reference to Eligibility/Service Date Criteria Corrected Case Number REF segment notes
1.0	2011/11/11	Initial	Initial Version

Contents

1 - Introduction

1.1 - Scope

Please note that this document is intended as a supplement to the companion guide published by the Michigan Department of Health and Human Services (MDHHS). The MDHHS companion guide should outline search criteria supported by Michigan Medicaid and the Benefit Plan information return in the 271 response.

We will do our best to keep this document in line with the MDHHS companion guide; however, instructions for implementing ISA/GS segments, and submitting transactions are specific to the MPHI eligibility clearinghouse and may differ from instructions provided in the MDHHS Companion Guide.

1.2 - References

Enrollment Information and the latest version of this Health Plan Benefits Companion Guide
https://hpb.mihealth.org/v2/public

Michigan Medicaid Provider Enrollment
https://www.michigan.gov > Providers > Provider Enrollment

Michigan Department of Community Health Companion Guides (HIPAA 5010 270/271)
http://www.michigan.gov/providers > Trading Partners > HIPAA - Companion Guides

ASC X12 Technical Reports, Addenda, and Errata for the Health Care Eligibility Benefit Inquiry and Response transactions (005010X279A1)
http://www.wpc-edi.com/

CORE Rules: HIPAA 5010 Updates
https://www.caqh.org/

2 - Getting Started

2.1 - Working with the Michigan Public Health Institute (MPHI)

The ability to successfully and effectively work with our Trading Partners is a goal of MPHI. The information that follows is presented to inform our Trading Partners and to enable the successful exchange of Michigan Medicaid eligibility information.

MPHI can accept Real-Time and Batch HIPAA 270/271 transactions from all Providers, Billing Agents, and Clearinghouses registered with CHAMPS. These services are provided on behalf of MDHHS and are available free-of-charge.

2.2 - Trading Partner Requirements

The exchange of Michigan Medicaid eligibility information requires the requesting entity to have the following:

- A Trading Partner Agreement with the Michigan Department of Health and Human Services (MDHHS).
- A valid and active Michigan Medicaid service provider identification number.
- The ability to generate a HIPAA compliant 270 Health Care Eligibility Request transaction.
- The ability to receive and translate a HIPAA compliant 271 Health Care Eligibility Response transaction.

2.3 - Trading Partner Enrollment

Please follow the Implementation Checklist outlined in section 10.2 of this document. It will outline the steps you need to follow to establish your organization as a Trading Partner with MPHI.

3 - Testing with the Michigan Public Health Institute

Trading partners are expected to conduct the following testing steps before accessing the Production Environment. This testing is required to ensure that Trading Partners submit transactions in a manner that doesn't cause unexpected problems or negatively impacts the service for others.

3.1 - Compliance Testing

Verify that the Eligibility Inquiry (270) requests you're generating comply with the ASC X12 standards for this transaction and implement the control segments/envelopes outlined in this document. The goal of this testing step is to verify that you are generating a transaction that our clearinghouse can process.

Note: The use of a third-party validation tool is strongly encouraged.

3.2 - Transmission Testing

Submit several test transactions using the connectivity method you've selected for use with our Clearinghouse. Verify that you're getting a valid eligibility response for the request that you've submitted. The goal of this testing step is to confirm that you can implement one of our connectivity methods and submit a valid transaction.

3.3 - Unit Testing

Submit test transactions for the various Benefit Plans that your organization is interested in reviewing. Make sure that you're following the Michigan Medicaid Business Rules and Limitations specific to the information that you're interested in collecting. This testing step is for your own purposes, to ensure that you can get the expected results from our Clearinghouse.

3.4 - Performance Testing

Submit a simulated work-load that is a representation of the traffic /volume that you expect to submit in the production environment. If you're retransmitting failed transactions, make sure that you're following the Retransmission Guidelines.

4 - Communications

4.1 - Real-Time vs. Batch Transactions

Real-Time transactions consist of a single eligibility request (for one individual) where an immediate response to that request is expected. This transaction is assumed to be synchronous where the application sending a request waits for the response, which is returned within the same session.

Batch transactions consist of one or more eligibility requests comprised of multiple individuals where an immediate response is not expected. This type of transaction is typically asynchronous; where an application sending a request either polls for a response or is pushed a response when the entire batch of requests has been completed.

4.2 - Bulk Submission

Some Trading Partners may use the Real-Time service to process large amounts of eligibility transactions (that do not need to be processed in real-time) by submitting multiple real-time requests simultaneously and in rapid succession. MPHI requests that these Trading Partners follow this set of guidelines when using the Real-Time service in that manner:

- Submit requests outside of the regular business hours of 8:00 AM to 6:00 PM
- Limit the number of simultaneous HTTP requests (threads) to 10.
- Follow the Retransmission Guidelines as outlined in 4.4.4

4.3 - Connection Methods

4.3.1 - Basic Web-service (Real-Time)

This web-service allows providers to submit individual eligibility requests using a single Date of Service (DOS) or DOS span. An immediate real-time response is made for each eligibility request.

This service is based on the CORE Phase I Connectivity Rule.

4.3.2 - SOAP Web-Service / MIME Multipart (Real-Time/Batch)

These web-services allow users to submit a single real-time request with immediate response or a batch file using a single DOS or DOS span and receive a response file within 24 hours. Typically, batch responses should be returned within an hour. Factors such as file size and number of files being processed can slow response time.

These services are based on the CORE Phase II Connectivity Rule (version 2.2.0).

4.3.3 - Health Plan Benefits Website (Real-Time/ Batch)

The Health Plan Benefits website also provides a tool for Trading Partners to Submit, Retrieve, and Track Batch requests. If Trading Partners aren't interested in implementing one of the web-service interfaces, they are permitted to use this tool as an alternative. The website can be found at the following location: https://hpb.mihealth.org/v2

4.4 - Basic Web-service Specifications

4.4.1 - Transmission

Eligibility requests are submitted to the MPHI Clearinghouse through the HTTP POST method. Each HTTP Request consists of an authentication header with the Trading Partners username/password, and a message body containing a 270 Eligibility Request. Upon authentication and validation of the submitted 270 Eligibility Request, the Clearinghouse processes the request and returns an HTTP Response containing a HIPAA 271 Eligibility Response in the message body.

4.4.2 - Authentication

Transactions are authenticated using the Basic authentication method outlined in the HTTP/1.0 specification. Through this method both the username and password are encoded as a sequence of Base64 characters and submitted in the message header. It is important to note that that Basic authentication without the addition of HTTPS is not a secure authentication method. The Base64 encoding is only intended to obscure the password from being read directly by a person. However, all requests submitted via HTTPS are encrypted and should be considered secure.

The following algorithm outlines how the Authorization header is created:

Authorization = "Basic" base64-user-pass

user-pass = username ":" password
username = *<TEXT excluding ":">
password = *TEXT

For example, the username “Aladdin” and the password “open sesame” would be encoded as the following:

Authorization: Basic QWxhZGRpbjpvcGVuIHNlc2FtZQ==

4.4.3 - Error Handling

There are two logical layers used to validate and process requests in the Basic Web-Service.

- HTTP Layer
- Payload Processing Layer

In each of these layers, processing is halted if an error is detected. If the HTTP Layer responds with an error, then the Payload Processing Layer will not be executed. Since the Payload Processing Layer is the final stage, it will always return a payload of TA1, 999, or 271.

Status Codes returned by the HTTP Layer:

- 200 OK - The request was completed successfully and a 271 Eligibility Response (or 999 Acknowledgement for an invalid 270) transaction has been returned.
- 403 Forbidden – Unable to authenticate or authorize the Trading Partner.
- 500 Internal Service Error – Unable to process the HIPAA 270 request.
- 503 Service Unavailable – Service unavailable to process any requests.

Responses from the Payload Processing Layer:

- 271 – Processing of the Payload was successful
- 271 2100A AAA 80 – Timeout occurred requesting data from the Information Source (CHAMPS)
- 271 2100A AAA 42 – Error occurred requesting data from the Information Source (CHAMPS)
- 271 2000A AAA 42 – Internal Error has occurred processing the Eligibility Request
- 271 2100A AAA 50 – This response is received when a trading partner has not associated MPHI as a billing agent in CHAMPS
- 999 (Implementation Acknowledgement) - Errors exist in the X12 syntax of the 270 Request
- TA1 (Technical Acknowledgement) - Errors exist in the Interchange Envelope

4.4.4 - Retransmission Guidelines

If a response to the HTTP Request is not received within a 60 second period, Trading Partners should timeout their request, and send a duplicate transaction no sooner than 30 seconds after the original attempt. If no response is received after the second attempt, the Trading Partner should submit no more than 5 duplicate transactions within the

next 15 minutes. If the additional attempts result in the same timeout termination, the Trading Partner should contact Medicaid Eligibility Support for assistance.

4.4.5 - Sample Code

The following code snippet provides an example of how a Trading Partner might implement a 270 Eligibility Request transaction in VB.Net:

```
Dim RequestText As String

Dim Username As String = "biztalkpartner"
Dim Password As String = "123Partner"
Dim URL As String = "https://xx.xx.xxx.xxx/Medicaid/BTSHTTPReceive.dll"

Dim Encoding As New ASCIIEncoding
Dim Authentication() As Byte, Authorization As String

Dim WebRequest As HttpWebRequest, WebResponse As WebResponse
Dim RequestStream As Stream, ResponseStream As Stream
Dim RequestWriter As StreamWriter, ResponseReader As StreamReader

'Basic Authentication
Authentication = Encoding.ASCII.GetBytes(String.Format("{0}:{1}", Username, Password))
Authorization = "basic " & Convert.ToBase64String(Authentication)

'Config Request
WebRequest = HttpWebRequest.Create(URL)
WebRequest.ContentType = "application/x-www-form-urlencoded"
WebRequest.Method = "POST"
WebRequest.Headers.Add("Authorization", Authorization)
WebRequest.Timeout = 30000 'Optional
RequestStream = WebRequest.GetRequestStream()

'Write Request
RequestWriter = New StreamWriter(RequestStream, Encoding.ASCII)
RequestWriter.Write(RequestText)
RequestWriter.Flush()
RequestWriter.Close()

'Request-Response
WebResponse = WebRequest.GetResponse()

'Read Response
ResponseStream = WebResponse.GetResponseStream()
ResponseReader = New StreamReader(ResponseStream, Encoding.ASCII)
```

4.5 - SOAP / MIME Multipart Specifications

These web-services implement the CAQH Core Phase II Connectivity Rule (version 2.2.0). Please review the CAQH CORE Rules (HIPAA 5010 Updates) for further details.

https://www.caqh.org/

Only the payload types for the Health Care Eligibility Benefit Inquiry and Response are supported:

Mode	Request	Response
Real-Time	X12_270_Request_005010X279A1	X12_271_Response_005010X279A1 X12_999_Response_005010X231A1 X12_TA1_Response_00501X231A1
	<invalid request>	CoreEnvelopeError
Batch	X12_270_Request_005010X279A1 X12_005010_Request_Batch_Results_271 X12_005010_Request_BatchSubmissionMixed	X12_BatchReceiptConfirmation X12_271_Response_005010X279A1 X12_005010_Response_BatchSubmissionMixed
	X12_TA1_RetrievalRequest_00501X231A1 X12_999_RetrievalRequest_005010X231A1 X12_005010_Request_Acks	X12_TA1_Response_00501X231A150 X12_999_Response_005010X231A1 X12_005010_Response_Acks
	X12_Request_ConfirmReceipt	X12_Response_ConfirmReceiptReceived
	<invalid request>	CoreEnvelopeError

4.5.1 - Transmission Methods

SOAP

Eligibility requests are submitted to the MPHI Clearinghouse as a SOAP Request containing Username/Password information in the SOAP Header and metadata and payload information in the SOAP Body. Depending on the message type (and payload type) of the request a response will be provided containing an 271 Eligibility Response, an acknowledgement file, or a receipt that a Batch Request has been successfully submitted.

MIME Multipart

Eligibility requests are submitted to the MPHI Clearinghouse as an HTTP / MIME Request containing Username/Password information as POST parameters. Depending on the message type (and payload type) of the request a response will be provided containing an 271 Eligibility Response, an acknowledgement file, or a receipt that a Batch Request has been successfully submitted.

4.5.2 - Error Handling

There are three logical layers used to validate and process each request in the MIME and SOAP Web-Services.

- HTTP Layer
- Envelope Processing Layer
- Payload Processing Layer

In each of these layers, processing is halted if an error is detected. For instance, if the HTTP Layer responds with an error then the Envelop Processing Layer will not be executed. Since the Payload Processing Layer is the final stage it will always return a payload of TA1, 999, or 271.

HTTP Status Codes returned by the HTTP Layer:

- 200 OK - The request was completed successfully and a 271 Eligibility Response (or 999 Acknowledgement for an invalid 270) transaction has been returned.
- 403 Forbidden – Unable to authenticate or authorize the Trading Partner.
- 500 Internal Service Error – Unable to process the HIPAA 270 request.
- 503 Service Unavailable – Service unavailable to process any requests.

ErrorCode values returned in the Envelope Processing Layer:

- Success – Processing of the SOAP Envelope was successful
- <FieldName>Illegal – Invalid value submitted for this field
- <FieldName>Required – Required field not included in the Envelope
- ChecksumMismatched – Checksum doesn't match the Payload

Responses from the Payload Processing Layer:

- 271 – Processing of the Payload was successful
- 271 2100A AAA 80 – Timeout occurred requesting data from the Information Source (CHAMPS)
- 271 2100A AAA 42 – Error occurred requesting data from the Information Source (CHAMPS)
- 271 2000A AAA 42 – Internal Error has occurred processing the Eligibility Request
- 271 2100A AAA 50 – This response is received when a trading partner has not associated MPHI as a billing agent in CHAMPS
- 999 (Implementation Acknowledgement) - Errors exist in the X12 syntax of the 270 Request
- TA1 (Technical Acknowledgement) - Errors exist in the Interchange Envelope

4.5.3 - Retransmission Guidelines

If a response to a Real-Time Request is not received within a 60 second period, Trading Partners should timeout their request and send a duplicate transaction no sooner than 30 seconds after the original attempt. If no response is received after the second attempt, the Trading Partner should submit no more than 5 duplicate transactions within the next 15 minutes. If the additional attempts result in the same timeout termination, the Trading Partner should contact Medicaid Eligibility Support for assistance.

If a Batch Request has not completed within 24 hours, Trading Partners are permitted to cancel the initial request and resubmit another Batch Request. However, it is recommended that the Trading Partners contact Medicaid Eligibility Support if they feel that Batch files aren't processing in a timely manner.

5 - Contact Information

5.1 - Support

MPHI Center for Technology Solutions provides support for the Health Plan Benefits website and Medicaid Eligibility services. Please contact the MPHI support team with any questions regarding Health Plan Benefits website enrollment, Medicaid Eligibility, issue reporting, and/or service outages. The MPHI support team can be reached by email or phone at:

MPHI Center for Technology Solutions
Medicaid Eligibility Support Desk
MedicaidEligibility@mphi.org
517-324-6095

5.2 - State Medicaid Eligibility Provider Support

The State of Michigan Medicaid Eligibility Provider Support services can be reached by calling (800) 292-2550.

6 - Control Segments / Envelopes

6.1 - ISA-IEA

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		ISA	Interchange Control Header			
		ISA01	Authorization Information Qualifier	00		"00" (No Authorization Information Present)
		ISA03	Security Information Qualifier	00		"00" (No Security Information Present)
		ISA05	Interchange ID Qualifier	ZZ		"ZZ" (Mutually Defined)
		ISA06	Interchange Sender ID			Federal Employer Identification Number of Sender
		ISA07	Interchange ID Qualifier	ZZ		"ZZ" (Mutually Defined)
		ISA08	Interchange Receiver ID	383611960		Federal Employer Identification Number of Receiver (383611960)
		ISA12	Interchange Control Version Number	00501		"00501" (Version 5010)

		ISA14	Acknowledgement Requested	0		"0" (No Acknowledgement Requested)
		IEA	Interchange Control Trailer			
		IEA01	Number of Included Functional Groups	1*		Only one Functional Group is permitted for real-time transactions

6.2 - GS-GE

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		GS	Functional Group Header			
		GS01	Functional Identifier Code	HB, HS		"HB" (Eligibility, Coverage, or Benefit Information 271) "HS" (Eligibility Coverage or Benefit Inquiry 270)
		GS02	Application Sender's Code			Federal Employer Identification Number of Sender
		GS03	Application Receiver's Code	383611960		Federal Employer Identification Number of Receiver (383611960)
		GS08	Version Release/Industry Identifier Code	005010X279A1		
		GE	Functional Group Trailer			
		GE01	Number of Transaction Sets Included	1*		Only one Transaction Set is permitted for real-time transactions

6.3 - ST-SE

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		ST	Transaction Set Header			
		ST03	Implementation Convention Reference	005010X279A1		

7 - Michigan Medicaid Business Rules and Limitations

7.1 - Beneficiary Search Criteria

MDHHS supports the following data set search criteria outlined below:

- Primary Search Option:
  - Member ID (Beneficiary Id)
  - Member Full Name (First Name, Last Name)
  - Member Date of Birth
  - Member SSN
- Alternate Search Options:
  - Member ID (Beneficiary Id)
  - Identification Card Serial Number (Card Control Number stored on MIHealth Card)
  - Or any two of the following:
    - Recipient Full Name (First Name, Last Name)
    - Recipient Date of Birth
    - Recipient SSN
- Additional Alternate Search Options to identify a unique member if AAA 76 (Duplicate Subscriber/Insured ID Number) is returned in 271:
  - Gender Code
  - Postal Code

7.2 - Eligibility / Service Date Criteria

The Eligibility/Service dates requested in a 270 transaction are required to meet the following set of guidelines:

- Dates may not extend beyond the last day of the current month or more than 12 months prior to that date; with the exception that Inpatient Hospitals are permitted to query dates further in the past.
- Dates may not precede a beneficiary's date-of-birth or follow their date-of-death.
- Date ranges are limited to a span of 3 months

If the Eligibility/Service dates fail to follow these guidelines, the 271 response will not include any coverage information and return a 2100C AAA segment (AAA03 of "57", "60", "61", or "62").

7.3 - DSH Provider Support

Disproportionate Share Hospital (DSH) related eligibility inquiries are only available to providers enrolled under the Facility / Agency / Organization (FAO) enrollment type that have completed the DSH questions under the "Manage Provider Checklist" (in the CHAMPS-PE subsystem) and have received approval from MDHHS.

In order to submit a DSH inquiry, providers need to use a Service Type Code (EQ01) value of 48 instead of 30. When using the EQ01 value of 48, DSH providers are permitted to lookup eligibility information further than one year in the past.

Example:
DTP*472*RD8*20081001-20081031~
EQ*48~

7.4 - Primary Care Provider

The Primary Care Provider information will only be provided if the inquiry DOS range includes the current date and the beneficiary is actively enrolled in a Health Plan. If these conditions have not been met there will be no PCP response whatsoever.

7.5 - CSHCS Diagnosis Codes

The Diagnosis Codes of CSHCS beneficiaries are available to Authorized CSHCS Providers submitting an eligibility request for a Single Date of Service. Note: Due to limitations in the 271 transaction, only the first 8 Diagnosis Codes may be returned.

7.6 - Spend-Down Amount

Spend-down Amounts are only displayed for eligibility requests for the Current Month and Spend-down Amounts are only displayed if the Spend-down Benefit Plan is assigned for the entire month.

Note: Spend-down Amounts may not available for all beneficiaries assigned the Spend-down Benefit Plan.

Example (Spend-down amount returned):
EB*6**30~
EB*Y*IND*60*MC*SPENDOWN**600~
DTP*307*RD8*20110901-20110930~

Example (DOS exceeds current month)::
EB*6**30~
EB*Y*IND*60*MC*SPENDOWN**0~
DTP*307*RD8*20110801-20110930~

Example (Benefit Plan not assigned for entire month):
EB*6**30~
EB*Y*IND*60*MC*SPENDOWN**0~
DTP*307*RD8*20110901-20110916~

Example (Spend-down amount not available):
EB*6**30~
EB*Y*IND*60*MC*SPENDOWN**0~
DTP*307*RD8*20110901-20110930~

7.7 - MIHealth Card

The MIHealth card (“My Health”) is issued as an identification card to beneficiaries enrolled in Michigan Medicaid, Emergency Medicaid, Children’s Special Health Care Services (CSHCS) and Adult Benefits Waiver (ABW) programs. The following information is stored on the magnetic card stripe and can be used as identifiers in an eligibility request.

Track 1

SS	FC	Case Number	Member ID	Card Control Number	ES	LRC
		9 digits	12 digits (two leading zeroes)	12 digits (Member ID + Card Issue Count)		

SS – Start Sentinel (%)
FC – Format Code (B)
ES – End Sentinel (?)
LRC – Longitudinal Redundancy Check Character

Track 2

SS	Case Number	Member ID	Card Control Number	ES	LRC
	9 digits	12 digits (two leading zeroes)	12 digits (Member ID + Card Issue Count)		

SS – Start Sentinel (;)
ES – End Sentinel (?)
LRC – Longitudinal Redundancy Check Character

Example
%B1151459730010703387271070338727 03?;1151459730010703387271070338727 03?

8 - Transaction Specific Information

8.1 - 270 Health Care Eligibility Benefit Inquiry

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		ST	Transaction Set Header			
		ST01	Implementation Convention Reference	270		"270" (Eligibility, Coverage or Benefit Inquiry)
		ST03	Implementation Convention Reference	005010X 279A1		
		BHT	Beginning of Hierarchical Transaction			
		BHT03	Submitter Transaction Identifier			This element is tracked by MPHI for reference purposes.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2000A		Information Source Level			*Only one* Information Source *Loop permitted.*
	2100A	NM1	Information Source Name			
	2100A	NM101	Entity Identifier Code	PR		"PR" (Payer)
	2100A	NM102	Entity Type Qualifier	2		"2" (Non-Person Entity)
	2100A	NM108	Identification Code Qualifier	PI		"PI" (Payer Identification)
	2100A	NM109	Information Source Primary Identifier	D00111		"D00111"
	2000B		Information Receiver Level			*Only one* Information Receiver *Loop permitted.*
	2100B	NM1	Information Receiver Name			
	2100B	NM108	Identification Code Qualifier	XX, SV		"XX" (National Provider ID) "SV" (Service Provider Number)
	2100B	NM109	Information Receiver Identification Number		10, 7	National Provider ID (for XX) CHAMPS/Legacy ID (for SV) *The National Provider Identifier (NPI) must be used unless provider is exempt from NPI mandate.*
	2000C		Subscriber Level			*Only one Subscriber Loop permitted.*
	2000C	TRN	Subscriber Trace Number			*This segment will be returned in the 271 (if provided) but is no-longer tracked by MPHI.*
	2100C	NM1	Subscriber Name			*Information regarding Beneficiary Search Criteria permitted can be found in Section 7.1 of this document.*
	2100C	NM103	Subscriber Last Name			

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2100C	NM104	Subscriber First Name			
	2100C	NM108	Identification Code Qualifier	MI		"MI" (Member Identification Number).
	2100C	NM109	Subscriber Primary Identifier		10	Medicaid Beneficiary ID
	2100C	REF	Subscriber Additional Identification			
	2100C	REF01	Reference Identification Qualifier	GH, HJ, SY		“GH” (Identification Card Serial Number) “HJ” (Identity Card Number) "SY" (Social Security Number) *“GH” if using the Card Control Number and the card has been swiped; “HJ” if the Card Control Number is used and the card has not been swiped.*
	2100C	REF02	Subscriber Supplemental Identifier		9	Social Security Number
	2100C	N4	Subscriber City, State, Zip Code			
	2100C	N403	Postal Code			
	2100C	DMG	Subscriber Demographic Information			
	2100C	DMG02	Subscriber Birth Date			
	2100C	DMG03	Subscriber Gender Code	F, M		“F” (Female) “M” (Male)
	2100C	DTP	Subscriber Date			*Information regarding date time period search criteria can be found in Section 7.2 of this document.*
	2100C	DTP01	Date Time Qualifier	291		"291" (Plan)

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2100C	EQ	Subscriber Eligibility or Benefit Inquiry			*Information regarding DSH Provider Support can be found in Section 7.3 of this document.*
	2110C	EQ01	Service Type Code	30, 48 …		"30" (Health Benefit Plan Coverage) "48" (Hospital - Inpatient) …

8.2 - 271 Health Care Eligibility Benefit Response

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		ST	Transaction Set Header			
		ST01	Transaction Set Identifier Code	271		"271" (Eligibility, Coverage, or Benefit Information)
		ST03	Implementation Code Reference	005010 X279A1		
		BHT	Beginning of Hierarchical Transaction			
		BHT03	Submitter Transaction Identifier			Value received in 270
	2000A	AAA	Request Validation			*Indicates that an internal error has occurred*
	2000A	AAA01	Valid Request Indicator	Y		"Y" (Yes)
	2000A	AAA03	Reject Reason Code	42		"42" (Unable to Respond at Current Time)
	2000A	AAA04	Follow-up Action Code	R		"R" (Resubmission Allowed)
	2100A	NM1	Information Source Name			
	2100A	NM101	Entity Identifier Code	PR		“PR” (Payer)
	2100A	NM102	Entity Type Qualifier	2		"2" (Non-Person Entity)
	2100A	NM103	Information Source Last or Organization Name			MDHHS

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2100A	NM108	Identification Code Qualifier	PI		“PI” (Payer Identification)
	2100A	NM109	Identification Code	D00111		“D00111”
	2100A	AAA	Request Validation			*Indicates that an error has occurred requesting data from CHAMPS*
	2100A	AAA03	Reject Reason Code	42, 79, 80		"42" (Unable to Respond at Current Time) "79" (Invalid Participant Identification) "80" (No Response Received - Transaction Terminated)
	2100B	NM1	Information Receiver Name			
	2100B	NM101	Entity Identifier Code			Value received in 270
	2100B	NM102	Entity Type Qualifier			Value received in 270
	2100B	NM103	Information Receiver Last or Organization Name			Value received in 270
	2100B	NM104	Information Receiver First Name			Value received in 270
	2100B	NM105	Information Receiver Middle Name			Value received in 270
	2100B	NM107	Information Receiver Name Suffix			Value received in 270
	2100B	NM108	Identification Code Qualifier	XX, SV		Value received in 270
	2100B	NM109	Information Receiver Identification Number			Value received in 270
	2100B	AAA	Request Validation			

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2100B	AAA03	Reject Reason Code	43, 50, 51		"43" (Invalid/Missing Provider Identification) "50" (Provider Ineligible for Inquiries) "51" (Provider Not on File)
	2000C	TRN	Subscriber Trace Number			*This segment will be returned in the 271 (if provided) but is no-longer tracked by MPHI.*
	2100C	NM1	Subscriber Name			
	2100C	NM101	Entity Identifier Code	IL		"IL" (Insured or Subscriber)
	2100C	NM102	Entity Type Qualifier	1		"1" (Person)
	2100C	NM103	Subscriber Last Name			
	2100C	NM104	Subscriber First Name			
	2100C	NM105	Subscriber Middle Name			
	2100C	NM107	Subscriber Name Suffix			
	2100C	NM108	Identification Code Qualifier	MI		“MI” (Member Identification Number)
	2100C	NM109	Subscriber Primary Identifier		10	Medicaid Beneficiary ID
	2100C	REF	Subscriber Additional Identification			
	2100C	REF01	Reference Identification Qualifier	3H, SY		"3H" (Case Number) “GH” (Identification Card Serial Number) "SY" (Social Security Number)
	2100C	REF02	Subscriber Supplemental Identifier			Case Number contains the following information in a comma delimited format: <Case number>, <DHS Service County Code>, <DHS District Code>, <Worker Load #>, <DHS Phone Number>,

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						<Residence County Code> *Ex:* REF*3H*123456789,82,10,1111,5552221234,82~
	2100C	N3	Subscriber Address			
	2100C	N4	Subscriber City/State/Zip Code			
	2100C	AAA	Request Validation			
	2100C	AAA03	Reject Reason Code	57, 60, 61, 62, 75, 76		"57" (Invalid/Missing Date of Service) "60" (Date of Birth Follows Date of Service) "61" (Date of Death Precedes Date of Service) "62" (Date of Service Not Within Allowable Inquiry Period) "75" (Subscriber/Insured Not Found) "76" (Duplicate Subscriber/Insured ID Number)
	2100C	DMG	Subscriber Demographic Information			
	2100C	DTP	Subscriber Date			
	2110C	EB	Subscriber Eligibility or Benefit Inquiry			*See MDHHS Companion Guide for Benefit Plan details*
	2110C	REF	Subscriber Additional Identification			
	2110C	REF01	Reference Identification Qualifier	1L, 1W, F6		"IL" (Group or Policy Number) "1W" (Member Identification Number)

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						"F6" (Health Insurance Claim Number)
	2110C	REF02	Subscriber Eligibility or Benefit Identifier			If applicable, the recipient's policy number or member identification number under another insurer when the recipient is the known subscriber (i.e., recipient name matches policy holder name or policyholder name is blank and there is Other Third-Party Pay.
	2110C	DTP	Subscriber Date			
	2110C	DTP01	Date Time Qualifier	292, 295, 307, 636		"292" (Benefit) "295" (Primary Care Provider) "307" (Eligibility) "636" (Date of Last Update)
	2110C	DTP02	Date Time Period Format Qualifier	RD8		
	2110C	DTP03	Eligibility or Benefit Date Time Period			Benefit Period for TPL Coverage (for Benefit) Eligibility Period in a Medicaid Program (for Eligibility) Date Pending Coverage was Last Updated (for Last Update)
	2110C	MSG	Message Text			
	2110C	MSG01	Free-form Message Text			Benefit Plan Disclaimers *Ex: Refer to Medicaid Provider Manual/MDHHS website for further details on covered services including PA, copay and other requirements.* Worker Load Number (for Pending) *Ex: 29128286* HS code, OI Code, Last Updated Date (for TPL) *Ex: RX/Only Pharmacy,87,20090101*
	2115C	III	Subscriber Eligibility or Benefit			*Returned for "Authorized" CSHCS Providers*

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Additional Information			
	2120C	NM1	Subscriber Benefit Related Entity Name			
	2120C	NM108	Identification Code Qualifier	MI, PI, SV, XX		"MI" (Member Identification Number) "PI" (Payer Identification) "SV" (Service Provider Number) "XX" (National Provider ID)
	2120C	NM109	Benefit Related Entity Identifier			C (for PI) Third Party Member ID (for MI) CHAMPS Provider ID (for SV) National Provider ID (for XX)
	2120C	N3	Subscriber Benefit Related Entity Address			*Provider Service Address*
	2120C	N4	Benefit Related Entity City/State/ZIP Code			*Provider Service City/State/Zip*
	2120C	PER	Subscriber Benefit Related Entity Contact Information			*Provider Phone Number*

9 - Trading Partner Agreements

9.1 - Michigan Medicaid - Trading Partner Agreement

Trading Partners must comply with any and all requirements of their Trading Partner Agreement with Michigan Medicaid.

This Trading Partner Agreement is a condition of enrollment as a Provider/Billing Agent in CHAMPS.

9. 2 - Terms and Conditions

Organizations applying for access to MPHI's HIPAA 270/271 service for Michigan Medicaid must agree to the following Terms and Conditions.

Authorized Uses

Check eligibility for a patient currently being treated or serviced by you, or has contacted you about a treatment or service, or for whom you have received a referral from a provider that has treated or serviced that patient.

- Determine whether a beneficiary is enrolled in or has pending coverage in a program administered by Michigan Medicaid.
- Determine whether a beneficiary has Third Party Liability coverage in addition to Michigan Medicaid coverage.
- Determine beneficiary payment responsibilities.
- Determine proper billing.

Assurances

All Submitters

- Submitter requesting access must be an active Michigan Medicaid Provider registered in CHAMPS or a Billing Agent registered in CHAMPS associated with one (or more) active Providers.
- Submitter will ensure that proper security measures are in place to associate each 270 with the individual that submitted the inquiry.
- Submitter is fully accountable for all transactions submitted and will cooperate with MPHI or its agents in the event that there is a security concern with respect to the any 270 submitted by the Organization to MPHI.
- Submitter will promptly contact MPHI in the event that the identity or contact information of the Support Contact changes, or if any of the assurances are no-longer met.
- Submitter will immediately cease transmission of 270 transactions to MPHI at such time any of the assurances herein provided are no longer met.
- Submitter will not disclose, lend, or otherwise transfer authentication information for this service to someone else.
- Submitter will not browse or use this service for unauthorized or illegal purposes.
- Submitter will comply with any and all requirements of their Trading Partner agreement with Michigan Medicaid.
- Submitter will comply with any and all HIPAA privacy regulations.
- Submitter must promptly notify MPHI if account is no longer in compliance or needs deactivation.
- Each eligibility inquiry will be limited to requests for eligibility data with respect to a patient currently being treated or serviced by you, or has contacted you about a treatment or service, or for whom you have received a referral from a provider that has treated or serviced that patient.
- Submitter will ensure proper security measures in place to associate each 270 submitted with the individual that submitted the inquiry.
- Submitter will only submit 270 transactions if they are a valid non-terminated Michigan Medicaid Provider.

All Clearinghouse/Billing Agent Submitters

- Clearinghouse will release eligibility data only to active Michigan Medicaid Providers (or their Billing Agents) for their specific purposes. Clearinghouse will not disclose information to anyone other than the Provider submitting the inquiry.
- Clearinghouse will only submit inquiries on behalf of Providers they are associated with as a Billing Agent in CHAMPS.
- Clearinghouse will be able to associate each 270 with the Provider that submitted the inquiry.
- Clearinghouse will ensure that Providers utilizing the Clearinghouse have proper security measures in place to associate each 270 submitted with the individual that submitted the inquiry.
- Clearinghouse will ensure that any 270 inquiry prepared by a Provider utilizing their service is compliant with any HIPAA and/or Companion Guide rules for this transaction.

All Provider Submitters

- Each eligibility inquiry will be limited to requests for eligibility data with respect to a patient currently being treated or serviced by you, or has contacted you about a treatment or service, or for whom you have received a referral from a provider that has treated or serviced that patient.
- Provider will ensure that proper security measures are in place to associate each 270 submitted with the individual that submitted the inquiry.
- Provider will only submit 270 transactions if they are a valid non-terminated Michigan Medicaid Provider.

10 - Appendices

10.1 - System Hours of Availability

MPHI development and production environments are regularly available twenty-four hours a day, seven days a week; with exceptions for regularly scheduled CHAMPS Maintenance Windows and CHAMPS Code Releases.

10.1.1 - CHAMPS Maintenance Window

CHAMPS has a regularly scheduled maintenance window on the third Saturday of each month that takes MPHI Eligibility services offline between 6:00 PM Saturday and 6:00 AM Sunday.

CHAMPS also has a maintenance window every Sunday from 8:00 AM to 10:00 AM. MPHI might take advantage of these service windows to conduct additional maintenance including hardware upgrades, service patches, etc.

MPHI Eligibility services cannot be restored until maintenance on both systems has been completed.

10.1.2 - MPHI Eligibility Maintenance Window

MPHI Eligibility has a regularly scheduled maintenance window on the Saturday after the second Tuesday of each month that takes MPHI Eligibility services offline between 6:00 PM Saturday and 6:00 AM Sunday.

10.1.3 - CHAMPS Code Releases

CHAMPS has an ongoing release schedule that includes enhancements and code fixes on a monthly/quarterly basis. These releases are typically scheduled on Fridays and require the CHAMPS system to be offline for several hours from 7:00 pm to 11:00 pm.

10.1.4 - Regular Business Hours

Submitters using the real-time system to submit transactions, where an immediate real-time response isn't requisite, are strongly encouraged to limit their request volume during regular business hours when the highest volume of real-time traffic is expected. This period has been identified by MPHI as 8:00 AM to 6:00 PM EST/EDT on weekdays and 8:00 AM to 3:00 PM on Saturdays.

10.2 - Implementation Checklist

Step 1 - Review Companion Guides

Download and review the MDHHS/MPHI Companion Guides to determine your organization's readiness to submit eligibility transactions with MPHI and identify the eligibility verification services you are interested in using.

https://hpb.mihealth.org/v2/public

Step 2 - Enroll with Michigan Medicaid via CHAMPS

Enroll in CHAMPS if you are not already a registered Provider or Billing Agent. Clearinghouses must enroll as a Billing Agent as CHAMPS doesn't distinguish between these roles.

http://www.michigan.gov/providers > Providers > Provider Enrollment

Step 3 - Associate Billing Agents via CHAMPS

Billing Agents and Clearinghouses will also need to be associated (in CHAMPS) with the Providers they represent to be able to submit transactions on their behalf. In addition, MPHI must also be associated as a Billing Agent for all Providers using our services (in addition to any Billing Agent or Clearinghouse submitting eligibility requests).

http://www.michigan.gov/providers > Providers > Provider Enrollment

For instructions on how to associate MPHI as a billing agent, please click here.

Step 4 - Complete MPHI's Online Registration Form

Once you have been established as a Medicaid Trading Partner in CHAMPS, fill-out MPHI's online registration form. Please allow 5-10 business days for MDHHS to review your application. MPHI will contact you with login/password and instructions on how to use our HIPAA 270/271 web-services once your application has been approved.

https://hpb.mihealth.org/v2/public

10.3 - What Medicaid Eligibility Services does MPHI offer?

Method		**Real-Time**	**Batch**
	Definition	Single Subscriber per Request (1 Subscriber) *Synchronous*	Multiple Subscribers per Request (10,000+ Subscribers) *Asynchronous*

Website	Description	Web Interface (DDE)	Submit EDI Batch Files via a Web Interface
	Benefit	No Implementation Required	Easy Implementation Supports Email Notifications View Batch File Progress
	Drawback	Requires manual lookup for each Subscriber	Requires manual Submission/Retrieval of 270/271 files
Basic Web-service	Description	Submit 270 via HTTP Request (CORE Phase I)	n/a
	Benefit	Easy Implementation Eligibility Requests Automated Low System Overhead	n/a
	Drawback	Batch not Supported Software Integration Required	n/a
SOAP / MIME multipart Web-service	Description	Submit 270 via SOAP Request (CORE Phase II)	Submit 270 via SOAP Request (CORE Phase II)
	Benefit	Eligibility Requests Automated Same Interface as Batch	Eligibility Requests Automated Same Interface as Real-Time
	Drawback	Software Integration Required High System Overhead	Software Integration Required

10.4 - Benefit Plan ID Codes

These codes are listed after the Benefit Plan ID (Ex. MA-MC-Q where Q is the benefit ID Code).

Code	Description
A	Medicaid for aged SSI recipients
B	Medicaid for blind SSI recipients
C	Medicaid (Family Independence Program (FIP))
E	Medicaid for disabled SSI recipients
G	Healthy Michigan Program
H	Healthy Michigan Program
I	Refugee Assistance Program (payment and medical)
J	Refugee Assistance Program (Medicaid only)
L	Healthy Kids Medicaid and Medicaid for Pregnant Women
M	Medicaid for the aged

N	Medicaid for caretaker relatives and families with dependent children
O	Medicaid for the blind
P	Medicaid for the disabled
Q	Medicaid for persons under age 21
R	Repatriate Assistance Program
K	Ambulatory Prenatal Services (APS)