Original Source Data Submitter (OSDS)

X12 834 Plan Member Reporting Standard Companion Guide Transaction Information

Instructions Related to Transactions
Based on ASC X12 834 X318 Plan Member
Reporting Implementation Guide, Version 5010

Transaction Information Companion Guide
Version Number: 1.5 – June 2020

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Preface

Companion Guides (CG) may contain two types of data: instructions for electronic communications with the publishing entity (i.e., Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while at the same time ensuring compliance with the associated ASC X12 Implementation Guide (IG) i.e.,Transaction Instructions. Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

1 Transaction Instruction Introduction

1.1 Background

1.1.1 Overview of Plan Member Reporting Transactions

The Plan Member Reporting Transaction standards were developed to create standard transaction sets for exchanging Member Reporting data. These standards were defined for issuers to exchange this data with trading partners including: All Payer Claims Databases administrators, Health Insurance Exchange administrators and other data reporting entities.

The Plan Member Reporting transactions serve to:

- Support analysis performed by All Payer Claims Databases
- Support the Health Insurance Exchange reporting and analytical requirements
- Promote consistency in Plan Member Reporting
- Reduce administrative costs

1.1.2 HIPAA Role in Implementation Guides

The Health Care Transaction Reporting Implementation Guides were developed for use by the insurance industry. At this time, they have not been adopted as an HIPAA standard and are not HIPAA covered transactions.

1.2 Intended Use

The Transaction Instruction component of this Companion Guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents.

1.3 Exceptions

The New York State Department of Health (NYSDOH) selected these transactions to support the adoption of a single set of healthcare plan member reporting standards for the format, data elements and code sets to be used for reporting to All Payer Claims Databases. NYSDOH expects payers to collect, maintain and submit information contained within the plan member reporting transaction as required by the associated X12 Implementation Guides and this Companion Guide. This information is essential for NYSDOH to perform health care analytics. This companion guide conforms to the requirements of any associated ASC X12 Implementation Guide, and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

Table 1 X12 Implementation Guides below lists the X12N Implementation Guides for which specific Transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X318	Plan Member Reporting (834)
005010X231A1	Implementation Acknowledgment For Health Care Insurance (999)

Table 1: X12N Implementation Guides

The Implementation Guides are available at http://store.x12.org/

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N Implementation Guide.
NON-SHADED rows represent “data elements” in the X12N Implementation Guide.

Table 2: Instruction Table Legend

3.1 ASC X12/005010X318 Plan Member Reporting (834)

Loop ID	Reference	Name	Notes / Comments
	BGN	Beginning Segment	
	BGN08	Action Code	NYSDOH expects to receive “RX”- (Replace) for the weekly full file submission or “2” - (Change) for any correction files submitted.
1000A	N1	Submitter Name	
1000A	N103	Identification Code Qualifier	“46” (Electronic Transmitter Identification Number) is required.
1000A	N104	Submitter Identifier	The OSDS assigned Submitter Identifier provided with the EDI Registration Form. The Submitter Identifier is used to ensure the Secure File Transfer Protocol (SFTP) folders match the transaction submitter. If the Submitter Identifier is not valid for the SFTP inbox, the file will be rejected.
1000B	N1	Receiver Name	
1000B	N102	Receiver Name	“NYSDOH-APD” is required.
1000B	N103	Identification Code Qualifier	“46” (Electronic Transmitter Identification Number) is required
1000B	N104	Receiver Identifier	“OSDS” is required.
1000C	N1	Information Source	
1000C	N103	Identification Code Qualifier	The qualifier “94” (Code assigned by the organization that is the ultimate destination of the transaction set) should be used.

Loop ID	Reference	Name	Notes / Comments
1000C	N104	Information Source Identifier	This is the HIOS, NAIC, or OSDS assigned payer identifier for the members included within this transaction set. When an issuer has multiple identifiers that are applicable, e.g. HIOS, NAIC or OSDS assigned Payer ID the expected priority is: 1) HIOS 2) NAIC 3) OSDS assigned payer ID When the value reported is an NAIC code, the value must be preceded with an N in order to provide an explicit separation from HIOS values. For example, an NAIC code of 12344 would be reported as N12344. The relationship between submitter and payer identifiers must be known to the OSDS or the transaction set will be rejected. Only the issuer is authorized to establish the submitter/payer ID relationship within the OSDS. This is managed using the EDI Registration Form.
2000	INS	Member Level Detail	
2000	INS03	Maintenance Type Code	NYSDOH expects the Maintenance Type Code most applicable to the status of the individual. When there is no change since the last submission, NYSDOH expects the value of “030” be used. See section 1.4.4 and 1.4.5 of the X12 implementation guide for additional information on cancellations and terminations.
2000	REF	Member Taxpayer Identifier	
2000	REF02	Reference Identification	NYSDOH expects to receive the Member’s Taxpayer Identifier (Social Security number or ITIN) when available in Information Source’s system.
2000	REF	Member Supplemental Identifier	
2000	REF01	Member Supplemental Identifier	Use qualifier “6O” to provide a record level indicator in REF02 which will be returned in the 834RL in the Supplemental Identifier field. Submitters may provide a record level identifier that will be returned in the 834RL. This is intended to enable direct linkage between the submitted record and the response records. For Medicare Advantage members use qualifier “F6” to indicate the value in REF02 is the Medicare Beneficiary Identifier (MBI).

Loop ID	Reference	Name	Notes / Comments
2100	NM1	Member Name	
2100A	NM108	Identification Code Qualifier	"MI" (Member Identification Number) is required Transactions received with a "34" (Social Security Number) or "TA" Taxpayer ID Number will not be processed.
2100A	NM109	Member Identifier	NYSDOH expects to receive a unique member ID within the Issuer/Plan/Product reported in Loop 2750.
2100A	PER	Member Communications Numbers	NYSDOH expects to receive Member Communications Numbers when available in the Information Source System. The hierarchy of submitting communication qualifiers in 2100A Member Communications outlined below.
2100A	PER03	Member Communication Number Qualifier	The PER segment accommodates only three contact methods. If you have more than three methods to choose from, DOH expects communication methods to be reported following this hierarchy.: Work Phone Primary Alternate Email Telephone Extension When sending the PER segment, PER03 is a required element. The only available qualifiers in this position are for: Work Number, eMail Address, or TTY number. When none of these are available, NYSDOH expects to receive the residence or cell number using the OT qualifier.
2100A	PER05	Member Communication Number Qualifier	
2100A	PER07	Member Communication Number Qualifier	
2100A	N4	Member City, State, ZIP Code	
2100A	N405	Location Qualifier	Location Qualifier "CY" (County/Parish) or "ZZ" (Mutually Defined) is required.
2100A	N406	Location Identifier	When the location qualifier is "CY", a valid FIPS county code must be received for New York State addresses. When the location qualifier is "ZZ", NYSDOH must receive "R" (At Risk) or "H" (Homeless)
2100A	DMG	Member Demographics	
2100A	DMG04	Marital Status Code	NYSDOH expects to receive Marital Status Code when available in the Information Source System.
2100A	DMG05	Composite Race or Ethnicity Information	Composite category for race or ethnicity information

Loop ID	Reference	Name	Notes / Comments
2100A	DMG05-01	Race or Ethnicity Code	DMG05-01 should only be used when race/ethnicity is not provided or collected by the submitting entity. Submit race or ethnicity in DMG05-03. Use “7” (Not Provided) when the member does not provide the information. Use “8” (Not Applicable) when the information is not collected.
2100A	DMG05-03	Race or Ethnicity Code	NYSDOH expects to receive the appropriate Classification of Race or Ethnicity code. All CDC codes are accepted. The following are a subset of the CDC code set applicable to DMG05-01 for this implementation: "A" (Asian or Pacific Islander) report as "R2" (ASIAN); "B" (Black) report as "R3.01" (BLACK); "C" (Caucasian) report as "R5" (WHITE); "D" (Subcontinent Asian American) report as "R2.01" (ASIAN INDIAN); "F" (Asian Pacific American) report as "R4" (NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER); "G" (Native American) report as "R1.01" (AMERICAN INDIAN); "H" (Hispanic) report as "E1" (HISPANIC OR LATINO); "I" (American Indian or Alaskan Native) report as "R1" (AMERICAN INDIAN OR ALASKA NATIVE); "J" (Native Hawaiian) report as "R4.01.001" (NATIVE HAWAIIAN); "N" (Black (Non-Hispanic)) report as "R3.01" (BLACK) and "E2" (NOT HISPANIC OR LATINO); "O" (White (Non-Hispanic)) report as “R5" (WHITE) and "E2" (NOT HISPANIC OR LATINO); "P" (Pacific Islander) report as "R4" (NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER); "E" (Other Race or Ethnicity) report as "R9" (OTHER RACE)
2100A	EC	Employment Class	NYSDOH expects to receive Employment Class when available in the Information Source System.
2100A	HLH	Member Health Information	NYSDOH expects to receive Member Health Information when available in the Information Source System.
2100A	LUI	Member Language	NYSDOH expects to receive Member Language when available in the Information Source System. NYSDOH strongly encourages the collection and submission of this data. It is critical to the intended analytics anticipated to be part of quality measures.
2100D	NM1	Member Employer	NYSDOH expects to receive Member Employer information when available in the Information Source System.

Loop ID	Reference	Name	Notes / Comments
2100E	NM1	Responsible Person	NYSDOH expects to receive Responsible Person information when available in the Information Source System.
2100E	PER	Responsible Person Communication Numbers	NYSDOH expects to receive Responsible Person Communication Numbers information when available in the Information Source System.
2100E	N3	Responsible Person Street Address	NYSDOH expects to receive Responsible Person Street Address information when available in the Information Source System.
2200	DSB	Disability Information	NYSDOH expects to receive Disability Information when available in the Information Source System.
2300	HD	Benefit Coverage	
2300	HD01	Maintenance Type Code	NYSDOH expects the Maintenance Type Code most applicable to the status of the Insurance Line Code identified in HD03. When there is no change since the last submission, NYSDOH expects the value of “030” be used. See section 1.4.4 and 1.4.5 of the X12 implementation guide for additional information on cancellations and terminations. At this level cancellations are represented using code “002”.
2300	DTP	Maintenance Effective Date	NYSDOH expects this segment to be populated with the date the Maintenance Type code should be changed.
2300	DTP	Benefit Dates	
2300	DTP03	Date Time Period	Future dates will be accepted. In the case of a cancellation or delete record, the Benefit Begin date must equal the previously submitted Benefit Begin date.
2300	AMT	Health Coverage Policy Amount	

Loop ID	Reference	Name	Notes / Comments
2300	AMT01	Amount Qualifier Code	NYSDOH expects to receive at least two iterations of this segment. 1) Monthly Premium Amount 2) Annual Deductible Amount as applicable to the specific member's coverage Qualifiers are to be reported as follows: Required: Use code P3 to report the Monthly Premium Amount (For Medicare Advantage, this is the Member contribution) Required: Use code D2 to report the Individual's Deductible Amount (Report family deductible amounts only when there is not an amount specific to the individual). Situational: For Medicare Advantage, use code ZZ to report the Medicare Funded portion of the capitation/premium amount when available. Transactions received without reporting the required codes will be rejected.
2300	AMT02	Monetary Amount	NYSDOH Expects to receive the amount as defined by the qualifier in AMT01. NOTE: Because there are valid reasons/situations where the applicable amount for the member may be zero, NYSDOH offers the following guidance in populating the premium and deductible amount elements when there is no applicable amount or the amount is unavailable. Report the amount as '0' when: 1) When there is no applicable deductible for the member coverage, or 2) There is no applicable premium information because the member is not the subscriber, and all premium calculations are maintained/reported at the subscriber level only. Report the amount as '.01' when the applicable amount is either unknown or unavailable.
2300	REF	Benefit Coverage Policy Related Information	

Loop ID	Reference	Name	Notes / Comments
2300	REF01	Reference Identification Qualifier	NYSDOH expects to receive “1L” for reporting the Group Number when available in the Information Source System. Submitters may provide an Internal Control Number at the benefit level that will be returned in the 834 RL. This is intended to enable linkage between the submitted record and the response records. Use qualifier “X9” Internal Control Number to indicate the value in REF02. This will be returned in the 834RL in the Internal Control Number.
2310	NM1	Provider Name	NYSDOH expects to receive all providers as selected by the member for each applicable provider type (NM101 qualifiers).
2310	NM109	Provider Identifier	Use qualifier “XX” in NM108 to indicate the identifier reported in NM109 is an NPI. When an NPI is not available use the qualifier applicible to the identifier provided in NM109.
2310	N3	Provider Address	NYSDOH expects to receive address of the Providers primary location when available in the Information Source System.
2310	N4	Provider City, State, ZIP Code	NYSDOH expects to receive City, State, and Zip Code of the Providers primary location when available in the Information Source System.
2310	PER	Provider Communications Numbers	NYSDOH expects to receive Communication Number of the Providers primary location when available in the Information Source System.
2310	PRV	Provider Taxonomy Information	NYSDOH expects to receive Providers primary Taxonomy Information when available in the Information Source System.
2320	COB	Coordination of Benefits	NYSDOH expects to receive Coordination of Benefits Information when available in the Information Source System.
2330	NM1	Coordination of Benefits Related Payer	NYSDOH expects to receive Coordination of Benefits Related Payer Information when available in the Information Source System.
2330	N3	Coordination of Benefits Related Payer Address	NYSDOH expects to receive Coordination of Benefits Related Payer Address Information when available in the Information Source System.
2330	N4	Coordination of Benefits Related Payer City, State, Zip Code	NYSDOH expects to receive Coordination of Benefits Related Payer City, State, and Zip Code Information when available in the Information Source System.
2700	LX	Member Reporting Categories	The LX should be repeated for each iteration of the 2700/2750 combination. The first iteration should be “1”.
2750	N1	Reporting Category	

Loop ID	Reference	Name	Notes / Comments
2750	N102	Member Reporting Category Name	“Issuer_Plan_Product_ID” is required. Transactions received without this information will not be processed.
2750	REF	Reporting Category Reference	
2750	REF01	Reference Identification Qualifier	The qualifier of “18” (Plan Number) is required, and this is the only valid value expected by DOH. This qualifier is required in association with the Plan Number entered in REF02.

2750	REF02	Member Reporting Category Reference ID	NYSDOH expects to receive a 14 digit HIOS ID for both on-exchange and off-exchange ACA plans or a composite record consisting of the Issuer, Plan, and Product ID for non-ACA commercial or Medicare Advantage plans. HIOS Example: 12345NY0010001 For non-ACA commercial or Medicare Advantage, the expected composite must match a composite reported in the plan information tab of the EDI Registration form. For Medicare Advantage, the Medicare Advantage Composite would consist of up to 3 components (Issuer, Plan and Product). The components are separated by the right square bracket "]" and limited to 50 characters. Example: NAIC = N12345 CMS assigned Plan Contract Number i.e. (H3388) This typically starts with the value of "H" CMS Plan Benefit Package (PBP) assigned by CMS i.e. (001) This may be left blank but is preferred. This would be reported in the 2330B in the 837 and 2750 in the 834 as: N12345]H3388]001 The composite consists of up to three components (Issuer, Plan, and Product). The components are separated using a right square bracket “]” and is limited to 50 characters. Example scenarios follow: 1. A plan identified in the EDI Registration process using: • HIOS = 44344 • Plan ID = XZ987562 • Product ID = HD20PERCENT Would be reported as: 44344]XZ987562]HD20PERCENT 2. A plan identified in the EDI Registration process using: • NAIC = 12344 • Plan ID = XZ987562 • Product ID = HD20PERCENT Would be reported as: N12344]XZ987562]HD20PERCENT 3. If the plan related products are not enumerated, the Product ID component would not be populated: • NAIC = 12344 • Plan ID = XZ987562 • Product ID = <null> Would be reported as: N12344]XZ987562] CMS assigned Plan Contract Number i.e. (H3388) This typically starts with the value of "H"

Loop ID	Reference	Name	Notes / Comments
			CMS Plan Benefit Package (PBP) assigned by CMS i.e. (001) This may be left blank but is preferred. NAIC = N12345 This would be reported in the 2330B in the 837 and 2750 in the 834 as: N12345]H3388]001 The issuer ID must match the identifier provided in Loop ID 1000C N104 as discussed above. Transactions received without this information will not be processed.

Table 3: Plan Member Reporting (834

3.2 ASC X12/005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

There are no special clarifications necessary for this implementation.

4 Transaction Instruction (TI) Additional Information

4.1 Business Scenarios

None.

4.2 Payer Specific Business Rules and Limitations

4.2.1 Data Submitter File Submission

Every entity that exchanges transactions with the Original Source Data Submitter (OSDS) must enroll as a data submitter. Additional information about file submission is included in the OSDS Data Submitter Companion Guide, available on the NYS Health Connector page at https://nyshc.health.ny.gov/documents/39436/108308/osds_standard_companion_guide_data_submitter_information.pdf

4.2.2 Frequently Asked Questions

The FAQ will be provided to the issuers in the agenda and minutes of the weekly issuer call. Issuers can refer to NYS Health Connector OSDS page at https://nyshc.health.ny.gov/web/nyapd/apd-osds and OSDS email at: apd.osds@health.ny.gov to receive the weekly call invitations and materials.

4.3 Other Resources

As the instructions in this Companion Guide are not intended to be stand-alone requirements documents, the instructions herein must be used along with:

- The Implementation Guides or Technical Reports Type 3s (TR3s): http://store.x12.org/
- Non-medical code sets: www.wpc-edi.com
- The Data Submitter Companion Guide (Contains detailed information about Data Submitter registration and testing.)

The OSDS Help Desk is available for any questions at (877) 363-5630 or a ticket can be created through ServiceNow at https://optum.service-now.com/itss2 .

5 Appendix A: Proprietary Transaction Response for X12 X318 Plan Member Reporting

5.1 High Level File Characteristics

The table below describes the high level characteristics of 834RL response file.

Report Specifications	Description
File Name	X12 834 X318 Plan Member Reporting Response (834RL)
File Description	This is a proprietary 834RL response file that will be created as a record level acknowledgement which indicates the status of each member record in an 834 X318 Plan Member Reporting File. Tier 2 errors will be reported. Transactions that fail for one or more soft edits will be accepted. Transactions that fail any hard edits will be rejected. If a transaction contains both soft and hard edit errors, the transaction will be rejected. You will receive a response file for each file submitted.
Use of File	Used by the Issuers to identify the status of each member record.
Output Type	Pipe delimited text file
Users of File	Issuers

Table 4: 834 High-Level Response File Characteristics

5.2 Sample Pipe Delimited Text File

Included below is a sample of 834 pipe delimited text file (834RL).

Z12345|12345|TR.Z1234512345.834CC.W.130430135202.001.DAT|20190501|123456XY|123456XY|112233||ACCEPT

Z12345|12345|TR.Z1234512345.834CC.W..130430135202.001.DAT|20190501|654321AB|654321AB|223344||ACCEPT

Z12345|12345|TR.Z1234512345.834CC.W..130430135202.001.DAT|20190501|987654AB|987654AB|334455|66448811|REJECT|99999|00426|Invalid Member Zip Code|HARD

Z12345|12345|TR.Z1234512345.834CC.W.130430135202.001.DAT|20190501|45678900|45678900|445566|88223344|REJECT|20500101|00418|Invalid Member Birth Date|HARD

Z12345|12345|TR.Z1234512345.834CC.W.130430135202.001.DAT|20190501|654321AB|65432101|556677|55336644|ACCEPT||00420|Missing Member Race/Ethnicity Code|SOFT

Z12345|12345|TR.Z1234512345.834CC.W.130430135202.001.DAT|20190501|654321AB|65432111|556644|55336633|ACCEPT||00420|Missing Member Race/Ethnicity Code|SOFT

Z12345|12345|TR.Z1234512345.834CC.W.130430135202.001.DAT|20190501|24433307|24433307|667788|667788|REJECT||00433|Missing Deductible Amount|HARD

5.3 Pipe Delimited Text File Converted to Excel (column heading added)

The table below shows the 834 pipe delimited text file (834RL) converted to Excel.

Submitter ID	Information Source	Interchange Control Number	File Name	Created Date	Subscriber ID	Member ID	Supplemental Identifier	Internal Control Number	Record Status	Value Reported	Edit ID	Edit Description	Edit Status
Z12345	ABCDE	12345	TR.Z1234512345.834CC.W.130430135202.001.DAT	20190501	123456XY	123456XY	112233		ACCEPT				
Z12345	ABCDE	12345	TR.Z1234512345.834CC.W.130430135202.001.DAT	20190501	654321AB	654321AB	223344		ACCEPT				
Z12345	ABCDE	12345	TR.Z1234512345.834CC.W.130430135202.001.DAT	20190501	987654AB	987654AB	334455	66448811	REJECT	99999	00426	Invalid Member Zip Code	HARD
Z12345	ABCDE	12345	TR.Z1234512345.834CC.W.130430135202.001.DAT	20190501	45678900	45678900	445566	88223344	REJECT	20500101	00418	Invalid Member Birth Date	HARD
Z12345	ABCDE	12345	TR.Z1234512345.834CC.W130430135202.001.DAT	20190501	654321AB	65432101	556677	55336644	ACCEPT	NULL	00420	Missing Member Race/Ethnicity Code	SOFT
Z12345	ABCDE	12345	TR.Z1234512345.834CC.W130430135202.001.DAT	20190501	654321AB	65432111	556644	55336633	ACCEPT	NULL	00420	Missing Member Race/Ethnicity Code	SOFT
Z12345	ABCDE	12345	TR.Z1234512345.834CC.W.130430135202.001.DAT	20190501	24433307	24433307	667788	44112233	REJECT	NULL	00433	Missing Deductible Amount	HARD

Table 5: 834 Response Text File converted to Excel File

5.4 File Column Mapping

The table below describes all the columns that are used in 834 response file (834RL).

ID	Column Name	Table/Column Source	Column Format (i.e., currency, numeric, character)	Column Description
D1	Submitter ID	1000A – Submitter Name N104 – Submitter Identifier	Alphanumeric	The Submitter's ID
D2	Information Source	1000C – Information Source N104 – Information Source Identifier	Alphanumeric	The name of the submitter/issuer who provided the file
D3	Interchange Control number	ISA13 – Interchange Control Number	Alphanumeric	The unique Interchange Control Number
D4	File Name	The submitted file name	Alphanumeric	The submitted X12 834 X318 Plan Member Reporting file
D5	Created Date	BGN – Beginning Segment BGN03 – Transaction Set Creation Date	Numeric	The creation date reported in the BGN segment of the 834 X318
D6	Subscriber ID	2000 – Member level Detail REF02 – Subscriber Identifier	Alphanumeric	The submitted subscriber ID for the record
D7	Member ID	2100 – Member Name NM109 – Member Identifier	Alphanumeric	The submitted member ID for the record
D8	Supplemental Identifier	2000 – REF*6O Cross Reference Number	Alphanumeric	The value submitted in the REF*6O. Null values will be reported if a value is not submitted.
D9	Internal Control Number	2300 – REF01 = X9 Internal Control Number	Alphanumeric	The value submitted in the REF02 when REF01 = X9 – Reported only for errors at the 2300 and below. Null values will be reported if a value is not submitted.

ID	Column Name	Table/Column Source	Column Format (i.e., currency, numeric, character)	Column Description
D10	Record Status	N/A	Alphanumeric	Status of the Record: ACCEPT - Member Record sent to APD REJECT - Member Record not sent to APD
D11	Value Reported	N/A		Field value entered by Issuer. If there is a comma in this data value, the whole value field is enclosed by double quotes. For example, if the data is 2019,20, this field will be displayed as “2019,20” (Note: this field will be blank if Edit # field is blank or if the edit reported uses multiple fields).
D12	Edit ID	N/A	Numeric	Number of the OSDS proprietary Edit (error) (Note: this field will be blank if there are no edits reported for a record)
D13	Edit Description	N/A	Alphanumeric	Description of the OSDS proprietary Edit # (Note: this field will be blank if Edit # field is blank)
D14	Edit Status	N/A	Alphanumeric	Status (disposition) of the OSDS Edit: SOFT-accept HARD-reject (Note: this field will be blank if Edit # field is blank)

Table 6: 834 Response File Column Mapping

6 X12 Transaction Information Change Summary

Version	Date	Section(s) Changed	Change Summary
1.0	8/21/19		• Initial Version
1.1	10/23/19	3.1, 5, Appendix A, 4.2.1 and 4.4	• 1000A N104 Submitter Identifier updated comments • 1000B N102 Receiver Name updated comments • 1000C N1 Information Source updated comments • 1000C N104 Information Source Identifier updated comments • 2750 N102 Member Reporting Category Name updated format for value required • Clarification of 834RL report name in 5 and Appendix A • Updated OSDS Contact Information
1.2	11/20/19	3.1, 4.2.1 and 4.4	• 1000C N104 Information Source Identifier updated comments • 2100A DMG05 Composite Race or Ethnicity Updated comments • 2100A DMG05-01 Race or Ethnicity Code updated comments • 2100A DMG05-03 Race or Ethnicity Code updated comments • 2300 AMT02 Monetary Amount updated comments • 2750 REF01 Reference Identification Qualifier updated comments • 2750 REF02 Member Reporting Category • Reference ID updated comments • Updated verbiage for OSDS Help Desk
1.3	3/3/20	3.1, 5.1, 5.2, 5.3 and 5.4	• 1000A updated comments • 2300 AMT02 corrected comments • 2000 REF01 added verbiage for Medicare Advantage(MBI) • 2310 NM1 updated comments • 2310 NM109 updated comments • 2310 N3 updated comments • DMG05-01 updated comments • REF02 – 2750 – Updated comment • Added 2000 REF Member Supplemental Identifier • Added 2300 REF Benefit Coverage Policy Related information (9-Internal Control Number) • Change file naming convention in examples to NYOSDS

			• Added Interchange Control Number, Cross Reference Number and the Internal Control Number to the 834 RL • Added verbiage to PER segment for Member Communications • 2000; REF01 Member Supplemental Identifier: updated description • 2100A; DMG05-01 Race or Ethnicity: updated description
1.4	04/07/2020	Updated Section 3.1	• 3.1 2100 A FIPS • 3.1 PER • 3.1 2300 AMT01 & AMT02
1.5	6.23.2020	Updated example for 3.1	• SECTION 5.2 Example updated to Z12345|12345|TR.Z1234512345.834CC.W.1 from 1234|ABCDE|12345|HN.NYOSDS.834CC.W. • Section: 5.3 Submitter Id: updated from “1234” to Z12345 and File name from HN.NYOSDS.834CC.W to TR.Z1234512345.834CC.W • 2750 Ref 02: For Medicare Advantage, the Medicare Advantage Composite would consist of up to 3 components (Issuer, Plan and Product). The components are separated by the right square bracket "]" and limited to 50 characters. Example: NAIC = N12345 CMS assigned Plan Contract Number i.e. (H3388) This typically starts with the value of "H" CMS Plan Benefit Package (PBP) assigned by CMS i.e. (001) This may be left blank but is preferred. This would be reported in the 2330B in the 837 and 2750 in the 834 as: N12345]H3388]001

Table 7: Transaction Information Change Summary