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July 3, 2025

MEMORANDUM

MEMO NO.
QI-2516
CCS-2503

TO: QUEST INTERGRATION HEALTH PLANS
COMMUNITY CARE SERVICES

FROM: JUDY MOHR PETERSON, PHD
MED-QUEST DIVISION ADMINISTRATOR

SUBJECT: IMPLEMENTATION OF MANAGED CARE ENCOUNTER RECONCILIATION (MCER) MAINFRAME PROCESS

Med-QUEST Division (MQD) will be implementing the Managed Care Encounter Reconciliation (MCER) (aka "Magic File") mainframe process for Med-QUEST Health Plans effective September 15, 2025. MQD is creating an extract of encounters submitted by Health Plans to Hawaii's Prepaid Medical Management Information System (HPMMIS) to be generated for data reconciliation each month. Health Plans will receive monthly extracts of encounters submitted to HPMMIS for internal reconciliation and each Health Plan will share their results of reconciling their data against the MCER files with MQD to improve the completeness and accuracy of HPMMIS data in preparation for use in rate setting. Health Plan specific extracts will only be accessible to Hawaii Medicaid Health Plans and each Plan will only have access to their own respective data.

MCER Parameters
The MCER files will be considered the definitive source of truth for the file's time-period. In cases where there are discrepancies between a Health Plan's data sets and the MCER files, data should be reconciled to align with the MCER files. The MCER files will be limited to the generation of encounters datasets by health plan. Once generated, MCER files will be transferred to the Health Plans' secured FTP folder.

Data Fields
MCER files will contain the following data fields:

Form type	HP Paid Amount	Contract Type
Bill type	HP Allowed Amount	Ingredient Cost
Reconciliation Category	MDC Paid Amount	Dispensing Fee
HP claim no	INS Paid Amount	Number of Scripts
Patient account no	Bill Amount	Days Drug Supply
Adjudication status	TSN	Quantity Dispensed
CRN date	Diagnosis 1	HP Paid Date
Service begin date	Diagnosis 2	Days (Length of Stay)
Service end date	Diagnosis 3	Admit Date
HAWI ID	Diagnosis 4	HP submitted DRG
Service Provider ID	Prescription Number	HP Paid Date
CRN	NDC Code	Place of service

Additional information on the layout of the MCER files can be found in Appendix A and information on the mapping of MCER field names to HPMMIS and to 837 and National Council for Prescription Drug Programs (NCPDP) locations can be found in Appendix B.

MCER Extraction Dates
MCER data extracts will be generated monthly and will contain all encounters with a Claims Reference Number (CRN) that were processed through HPMMIS during the prior 36-month period. Encounter cycles run on the 1st and 3rd Wednesday of each month and MCER extracts will be generated within 5 days after the completion of the 2nd encounter cycle of the month (3rd Wednesday) and will contain all files included in that cycle. Files given to the Health Plans will be sorted by the following adjudication status: Pended, Adjudicated-Approved, Voided, MQD Denied, and Denied by Health Plan. Additional information on the encounter processing cycle is described in the HPMMIS Technical Encounter Guide.

Additional guidance on using the MCER files for data reconciliation will follow in a future memo.

If you have any questions, please contact: mqd-datarequests@dhs.hawaii.gov

Appendix A: MCER File Layout

Field	Name	Field Start Position	Field End Position	Length
CLM-HP-ID	HP ID	1-6	6	6
ADJU-STA	Adjudication Status	7	8	2
CRN-DAT	CRN date	9	16	8
CRN	CRN	17	31	15
HP-CLM-NO	HP Claim No	32	61	30
FORM-TYP	Form Type	62	62	1
RECONC-CAT	Reconciliation Category	63	64	2
AHCCCS-ID	HAWI ID	65	73	9
PAT-ACCT-NUM	Patient Account No	74	93	20
SER-PR-ID	Service Provider ID	94	99	6
SER-BEG-DAT	Service begin date	100	107	8
SER-END-DAT	Service end date	108	115	8
ADJU-PMT-DAT	HP Paid Date	116	123	8
BIL-AMT	Bill Amount	124	134	11
HP-ALLOW-AMT	HP Allowed Amount	135	145	11
MDC-PAID-AMT	MDC Paid Amount	146	156	11
OTH-CVG-PMT-AMT	INS Paid Amount	157	167	11
HP-PAID-AMT	HP Paid Amount	168	178	11
PRI-DIAG-CD	Primary Diagnosis	179	185	7
PRI-DIAG-CD-1	Diagnosis 2	186	192	7
PRI-DIAG-CD-2	Diagnosis 3	193	199	7
PRI-DIAG-CD-3	Diagnosis 4	200	206	7
PLACE-OF-SER-CD	Place of service	207	208	2
CN1-CODE	Contract Type (CN1 Code)	209	210	2
TRAN-SUB-NO	TSN	211	212	2
NDC	NDC Code (If Form Type = C)	213	223	11
RX-NUM	RX-Number	224	235	12
DISP-FEE-PD	Dispensing Fee	236	246	11
INGRED-COST-SUBMIT	Ingredient Cost	247	257	11
SUPL-DAY	Days Supply	258	260	3
ITM-QTY	Quantity Dispensed	261	270	10
NUM-REFL-ACT	NumScripts	271	272	2
BIL-TYP	Bill type	273	275	3
ADM-DAT	Admit Date	276	283	8
ACOM-DA	Days (Length of Stay)	284	286	3

DRG-CD	HP submitted DRG	287	289	3
FILLER	Filler	290	320	31

Appendix B: Data Mapping MCER Field Names to HPMMIS and 837/NCPDP Location

MCER Field Name	HPMMIS Table.FieldName	837/NCPDP Location	Note
Bill Type (EC810)	EC-FACL-CLM.FACL-TYP- CD	2300/CLM05-1 – Facility Type Code	
Reconciliation Category of Service	None (see note)	N/A	Derived from MedQuest user based logic.
HP Claim No	EC-MED-PYR.HP-CLM- NO	2330B/REF02 – Other Payer Claim Control Number	When 2330B/NM101 = "PR" And 2330B/NM109 (Other Payer Primary Identifier) =1000A/NM109 And REF01 = "F8" Original Reference Number Move REF02, ELSE None
(EC810)	EC-FACL-CLM.HP-CLM-NO	2330B/REF02 – Other Payer Claim Control Number	When 2330B/NM101 = "PR" And 2330B/NM109 (Other Payer Primary Identifier) =1000A/NM109 And REF01 = "F8" Original Reference Number Move REF02, ELSE None
(EC215)	EC-DRUG-DTL.HP-CLM-NUM	896 – Transaction ID	
Patient Account No (EC410)	EC-MED-CLM.PAT-ACCT-NUM	2300/CLM01 – Patient Control Number	
(EC810)	EC-FACL-CLM.PAT-ACCT-NUM	2300/CLM01 – Patient Control Number	
Adjudication Status	ADJU-STA	N/A	
CRN Date	Process Date	N/A	Converted from julian to gregorian

Service Begin Date (EC810) (EC215)	EC-PROF-DTL.SER-BEG- DAT EC-FACL-CLM.SER-BEG- DAT EC-DRUG-DTL.DISP-DAT	2400/DTP03/ 2400/DTP03 – Service Date 401-D1 – Date of Service	
Service End Date (EC810)	EC-PROF-DTL.SER-END- DAT EC-FACL-CLM.SER-END- DAT	2400/DTP03 – Service Date 2400/DTP03 – Service Date	When DTP01 = ‘472’ AND When DP02 = ‘D8’ When DTP01 = ‘472’ AND When DP02 = ‘D8’ When DTP01 = ‘472’ AND When DP02 = ‘D8’ When DTP01 = ‘472’ AND When DP02 = ‘D8’
HAWI ID (EC205) (EC810) (EC440)	EC-MED-CLM.CLM-RP-ID EC-FACL-CLM.CLM-RP-ID EC-DRUG-CL.CLM-RP-ID	2010BA/NM109 – Subscriber Primary Identifier 2010BA/NM109 – Subscriber Primary Identifier 302-C2 – Cardholder ID	When NM101 = "IL" And NM108 = "1 When NM101 = "IL" And NM108 = "MI"
Servicing Provider ID (EC205)	EC-MED-CLM.SER-PR-ID	2310B/REF02 – Rendering Provider Secondary Id	When 2310B/NM101 = "82" Rendering Provider And 2310B/REF01 = "1D" Move 2310B/REF02 Else Where 2010BB/NM101 = "85" Billing Provider, And 2010BB/REF01 = "1D"

(EC240) (EC215)	EC-FACL-CLM.SER-PR-ID EC-NCPDP-CLM.SER-PR- NPI	2310D/REF02 – Rendering Provider Secondary Id 201-B1 – Service Provider ID	When 2310D/NM101 = "82" Rendering Provider, And 2310D/REF01 = "1D" Move 2310D/REF02 Else Where 2010BB/NM101 = "85" Billing Provider, And 2010BB/REF01 = "1D" Move 2010BB/REF02
CRN (CLM NUM and LN NUM) (EC810) (EC215)	EC-MED-PYR.HP-CLM-NO EC-FACL-CLM.HP-CLM-NO EC-FACL-DTL.LINE-NUM	2330B/REF02 – Oher Payer Claim Control Number 2400/LX01 – Service Line Number 2300B/REF02 – Payer Claim Control Number 2400/LX01 – Service Line Number 896 – Transaction ID	When 2330B/NM101 = "PR" And 2330B/NM109 (Other Payer Primary Identifier) = 1000A/NM109 And REF01 = "F8" Original Reference Number When 2330B/NM101 = "PR" And 2330B/NM109 (Other Payer Primary Identifier) = 1000A/NM109 And REF01 = "F8" Original Reference Number
	CLM-NO	N/A	
	LN-NO	N/A	

HP Paid Amount (EC205)	EC-MED-PYR.PAID-AMT	2320/AMT02 – Payer Paid Amoun	MDC: If Sum of all 2320/AMT02 elements When 2320/SBR09 = "MA" or "MB" And 2320/AMT01 = "D" Move 2320/AMT02 Else PLAN PAID: When 2330B/NM109 = 1000A/NM109 And AMT01 = "D" Move AMT02 When None OTHER PAYER: When AMT01 = D (Payer Amount Paid) Move AMT02
(EC810) (EC215)	EC-FACL-PYR.HP-PAID- AMT EC-DRUG-PYR,PAID- AMT	2320/AMT02 – Payer Paid Amount 228/COB Primary Payer Paid Amount	When 2320/AMT01 = "D" (Payer Amount Paid)
HP Allowed Amount (EC205) (EC810)	EC-MED-DTL.HP-APPR- AMT EC-FACL-CLM.HP-APPR- AMT	2400/CN102 – Contract Amount 2300/CN102 – Contract Amount	When 2320/SBR09 = “MA” or “MB”
MDC Paid Amount (EC205)	EC-MED-DTL.MDC- PAID-AMT	2430/SVD02 – Service Line Paid Amoun	Medicare: When 2320/SBR09 = "MA" or "MB"
(EC810)	EC-FACL-CLM.MDC- PAID-AMT	2320/AMT02 – Payer Paid Amount	MDC: Where 2320B/SBR09 = "MA" or "MB" Move 2320/AMT02
(EC215)	EC-DRUG-PYR.AMT- PAID	234 – COB Secondary Payer Amount	When 238 – COB Secondary Payer ID = “MEDICARE”
INS Paid Amount (EC205)	EC-MED-DTL.OTH-CVG-PMT-AMTW	2430/SVD02 – Service Line Paid Amount	When Other Payer Primary Idenifier not equal to “MA” or “MB” or “MC”

(EC810) (EC215)	EC-FACL-CLM.OTH-CVG-PM-AMT EC-DRUG-PYR.AMT-PAID(2)	2320/AMT02 – Payer Paid Amount 234 – Secondary Payer Amount	If not HP-paid or MDC paid or Plan Paid (2330B/SBR09 = "MC" Move AMT02) THEN OTHER PAYER If - COB Secondary Payer ID = Other ID
Bill Amount (EC205) (EC215)	EC-MED-DTL-A.BIL-AMT EC-INST-CLM.TOT-CLM-CHRG EC-DRUG-DTL.BIL-AMT	2400/SV102 – Line Item Charge Amoun 2300/CLM02 – Total Claim Charge Amount 430-DU – Gross Amount Due	
TSN	EC-MED-CLM.TP-SUPL- ID	1000A/NM109 – Submitter Identifier	When NM101 = “41” and NM108 = “46” - Move Pos 7-9
(EC810)	EC-FACL-CLM.TP-SUPL- ID	1000A/NM109 – Submitter Identifier	When NM101 = "41" And NM108 = "46" Move Pos 7-9
Diagnosis 1	EC-MED-DTL.PRI-DIAG- CD	2400.SV107-1 – Diagnosis Code Pointer	Edit Workbook If SV107-1 = 1, move HI01-2 If SV107-1 = 2, move HI02-2 If SV107-1 = 3, move HI03-2 If SV107-1 = 4, move HI04-2 If SV107-1 = 5, move HI05-2 If SV107-1 = 6, move HI06-2 If SV107-1 = 7, move HI07-2

(EC810) (EC215)	EC-FACL-CLM.PRI-DIAG- CD EC-DRUG-DTL.DIAG-CD- 1	2300/HI01-2 – Principal Diagnosis Code 424-DO – Diagnosis Code (1)	If SV107-1 = 8, move HI08-2 If SV107-1 = 9, move HI09-2 If SV107-1 = 10, move HI10-2 If SV107-1 = 11, move HI11-2 If SV107-1 = 12, move HI12-2 When HI01-1 = "BK" (ICD-9), “ABK” (ICD- 10) Move HI01-2
Diagnosis 2	EC-MED-DTL.SEC-DIAG- CD	2400/SV107-2	If SV107-2 = 1, move HI01-2 If SV107-2 = 2, move HI02-2 If SV107-2 = 3, move HI03-2 If SV107-2 = 4, move HI04-2 If SV107-2 = 5, move HI05-2 If SV107-2 = 6, move HI06-2 If SV107-2 = 7, move HI07-2 If SV107-2 = 8, move HI08-2 If SV107-2 = 9, move HI09-2 If SV107-2 = 10, move HI10-2 If SV107-2 = 11, move HI11-2

(EC810)	EC-INST-CLM.OTH- DIAG-CD-1	2300/HI01-2 – Other Diagnosis Code 1	If SV107-2 = 12, move HI12-2 There can be two occurrences of the HI ""Other Diagnosis Code Segment."" Move the first 12 Diagnosis codes received, no matter what occurrence of the segment. Move HInn-2 Where HI0_-1 = "BF" (ICD-9), “ABF” (ICD-10) Move HInn-9 (Present on Admission Indicator)
(EC215)	EC-DRUG-DTL.DIAG-CD- 2	424 – Diagnosis Code (2)	

Diagnosis 3	EC-MED-DTL.OTH-DIAG- CD-1	2400/SV107-3 – Diagnosis Code Pointer	If SV107-3 = 1, move HI01-2 If SV107-3 = 2, move HI02-2 If SV107-3 = 3, move HI03-2 If SV107-3 = 4, move HI04-2 If SV107-3 = 5, move HI05-2 If SV107-3 = 6, move HI06-2 If SV107-3 = 7, move HI07-2 If SV107-3 = 8, move HI08-2 If SV107-3 = 9, move HI09-2 If SV107-3 = 10, move HI10-2 If SV107-3 = 11, move HI11-2 If SV107-3 = 12, move HI12-2
(EC810) (EC215)	EC-INST-CLM.OTH- DIAG-CD-2 EC-DRUG-DTL.DIAG-CD- 3	2300/HI03-2 – Other Diagnosis Code 424 Diagnosis Code (3)	See Above

Diagnosis 4 (EC810)	EC-MED-DTL.OTH-DIAG- CD-2 EC-INST-CLM.OTH- DIAG-CD-3	2400/SV107-4 – Diagnosis Code Pointer 2300/HI04-2 – Other Diagnosis Code	If SV107-4 = 1, move HI01-2 If SV107-4 = 2, move HI02-2 If SV107-4 = 3, move HI03-2 If SV107-4 = 4, move HI04-2 If SV107-4 = 5, move HI05-2 If SV107-4 = 6, move HI06-2 If SV107-4 = 7, move HI07-2 If SV107-4 = 8, move HI08-2 If SV107-4 = 9, move HI09-2 If SV107-4 = 10, move HI10-2 If SV107-4 = 11, move HI11-2 If SV107-4 = 12, move HI12-2 See Above
Contract Type (CN1 Code) (EC205) (EC810)	EC-MED-DTL.CN1-CD EC-FACL-CLM.CN1- CODE	2400/CN102 – Contract Type Code 2300/CN101 – Contract Type Code	When 2400/CN101 is present 01 – Diag Rel Group (DRG) 02 – Per Diem 03 – Variable Per Diem 04 - Flat 05 - Capitated 06 - Percent 09 - Other
Prescription Number (EC810)	EC-FACL-NDC.RX-NUM	2410/REF02 – Prescription Number	If Form Type = C When 2400 REF01 = "XZ" Move REF02
(EC215)	EC-DRUG-DTL.RX-NUM	402-D2 – Prescription/Service Reference Number	

NDC Code (EC810) (EC215)	EC-FACL-NDC.NDC-CD EC-DRUG-DTL.NDC-CD	2410/LIN03 – National Drug Code 407-D7 – Product/Service ID	If Form Type = C When LIN02 = "N4" Move LIN03
Ingredient Cost (EC215)	EC-DRUG-DTL.INGRED-COST-SUBMIT	409-D9 – Ingredient Cost Submitted	New
Dispensing Fee (EC215)	EC-DRUG-DTL.DISP-FEE	507-F7– Dispensing Fee Paid (Health Plan)	New
NumScripts (EC215)	EC-DRUG-DTL.-NUM-REFL-ACT	403-D3 – Fill Number	New
DaysSupply (EC215)	EC-DRUG-DTL.SUPL-DAY	405-D5 – Days Supply	New
Quantity Dispensed (EC215)	EC-DRUG-DTL.ITM-QTY	442-E7 – Quantity Dispensed	New
Days (Length of Stay)	N/A	N/A	For Form Type I (UB) This is a calculated value and -does not exist in the 837 Logic is discharge date -admit date Verify logic for DRG is needed.
Admit Date	EC-FACL-CLM.ADM-DAT	2300/DTP03	New For Form Type I
HP submitted DRG	EC-FACL-CLM.DRG-CD	2300/H101-2 -Diagnosis Related Group Code	New For Form Type I
DishDate	EC-FACL-CLM.SER-END- DAT	2300/DTP03 – Statement To Date	New For Form Type I When HI01-1 = "DR" Move HI01-2

HP Paid Date (Form Type A; I/L/O; NCPDP) EC810 EC205	EC-INST-PYR.ADJU- PMT-DAT EC-MED-ADJU.ADJU- PMT-DAT	2330B/DTP03 - Adjudication or payment date 2430/DP03 – Adjudication or payment date	New For Form Types I,A and NCPDP For Form Type I If EC-ADJU.OTH-PYR-IND = 'H' then EC-MED-ADJU.ADJU-PMT-DAT
Place of Service (EC205)	EC-MED-DTL.PLACE-OF- SER-CD	2400/SV105 – Place of Service Code	New For Form Type A When 2400/SV105 is present move SV105