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September 1, 2021

MEMORANDUM

MEMO NO.
QI-2124
CCS-2110

TO: QUEST Integration Health Plans
Community Care Services (CCS)

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: REQUIREMENT FOR HEALTH PLANS TO SUBMIT THE CN1 SEGMENT ON ENCOUNTERS

The purpose of this memorandum is to inform the Health Plans of an additional submission requirement for encounters submitted on 837I and 837P: the CN101 (Contract Type Code) segment. This requirement is effective starting December 1, 2021.

The Contract Type Code identifies the payment arrangement by which the Health Plan paid the provider for services rendered. Health Plans shall submit Contract Type Code for both the header or detail Loops of the 837: in Loop 2300 for the header and 2400 for the detail.

The level at which the claim is paid dictates where the CN1 is submitted. For example, for most facility claims that are paid at the full claim level ("header" level), the CN1 code applies to the whole claim, and the CN101 segment should be completed in Loop 2300. For most other types of services where each claim line is paid separately, the CN1 code is a component of each line, and the CN101 segment should be completed in Loop 2400.

Encounters submitted without a Contract Type Code in either Loop 2300 or Loop 2400 will pend with Z172: Contract Code is invalid.

The Health Plan shall populate the CN101 Contract Type Code in Loop 2300 or Loop 2400 with one of the following codes:

Contract Type Code	Description	Definition
01	Diagnosis Related Group (DRG)	Used to report services paid under a DRG arrangement
02	Per Diem	A contract which allows certain charges to be on a rate per day basis
03	Variable Per Diem	A contract which allows certain charges to be on a rate per day basis, where the rate may not remain constant
04	Flat	A contract between the provider of a service and the destination payor whereby the flat rate charges may differ from the total itemized charges
05	Capitated	A contract between the provider of service and the destination payor which allows payment to the provider of service on a per member per month basis
06	Percent	Used to report services paid under a Percent arrangement
09	Other	Used to report services paid under Fee-for-service arrangement

The Health Plan shall continue to populate the CN102 Contract Amount segment in Loop 2300 and Loop 2400 for all encounters. The Health Plans will use this segment to report on the Health Plan Allowed Amount for the claim and claim line. The CN102 segment is required for all encounters. Med-QUEST will create an edit that verifies the CN102 segment is appropriately populated; if left blank, the edit will pend the encounter. This requirement is also effective December 1, 2021.

Loop ID	Reference	Name	Codes/Notes/Comments
2400	**CN1**	**CONTRACT INFORMATION**	This segment must always be sent for each line to capture the Health Plan Allowed Amount
2400	CN101	Contract Type Code	01 Diagnosis Related Group (DRG) 02 Per Diem 03 Variable Per Diem 04 Flat 05 Capitated 06 Percent 09 Other (use for FFS) **Expect any value**
2400	CN102	Contract Amount	Expect Health Plan Allowed Amount Allowed Amount: What would have paid under FFS before other payer

Loop ID	Reference	Name	Codes/Notes/Comments
2300	**CN1**	**CONTRACT INFORMATION**	This segment must always be sent for each line to capture the Health Plan Allowed Amount
2300	CN101	Contract Type Code	01 Diagnosis Related Group (DRG) 02 Per Diem 03 Variable Per Diem 04 Flat 05 Capitated 06 Percent 09 Other (use for FFS) **Expect any value**
2300	CN102	Contract Amount	Expect Health Plan Allowed Amount Allowed Amount: What would have paid under FFS before other payer

Please contact Kate Allen, sallen@dhs.hawaii.gov with any questions.