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March 9, 2022

MEMORANDUM

MEMO NO.
QI-2203 [Replaces QI-2124]
CCS-2202 [Replaces 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 that this memo replaces QI-2124, CCS-2110 which was previously issued on August 25, 2021. The following updated content will apply under the QI contract RFP-2022-008.

Effective April 1, 2022 for claims with start dates on or after December 1, 2021, Health Plans are required to report the CN1 segment, including CN101 (Contract Type Code) and CN102 (Contract Amount) for all encounters submitted on 837I and 837P.

Contract Type Code identifies the payment arrangement by which the Health Plan paid the provider for services rendered.

For 837P, Health Plans shall report the CN1 segment in Loop 2400 at the line level. For 837I, Health Plans shall only report the CN1 segment in Loop 2300, the "header."

Health Plans are only required to submit the CN1 segment on paid encounters, including zero-paid encounters; the CN1 segments should not be submitted on denied claims or denied lines.

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.