Hawaii PMMIS

Hawaii Prepaid Medical Management Information System

Technical Guide

Encounters

Version 4.0

February, 2024

1. Contents

2. Preface

2.1. Purpose

The Technical Guide – Encounters is distributed to medical and behavioral health plans contracting with the Hawaii Department of Human Services (DHS), Med-QUEST Division (MQD) to further their understanding of the policies and procedures for encounter acceptance and processing. This manual contains the definitions of the different types of encounters and the policies for encounter submission deadlines.

2.2. Definitions

241	Encounter Input Detail Report. This report lists encounters pended or denied during the encounter processing cycle.
277CA	Claims Acknowledgement File. This file is generated for every 837 health plans submit.
277U	The 277U Status File includes all finalized encounter records, as well as all pended encounter records, following adjudication processing.
824	Acknowledgement file for HIPAA level 3-7 errors
834	Daily file MQD generates for each health plan listing active MQD recipients enrolled in that health plan
999	Acknowledgement file for HIPAA level 1-2 errors
Adjudicated Claim	A claim that has been received and processed by the health plan which resulted in a payment or denial of the claim.
CIS	Community Integration Services; a MQD program designed to provide supportive housing services to individuals experiencing homelessness
CMS	Centers for Medicare and Medicaid Services which as oversight responsibilities for the MQD program, including encounter reporting
Clean Claims	A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity
CRN	Claims Reference Number; A unique 15-digit number assigned to each encounter record by MQD for tracking purposes. The first five numbers of the CRN contain the Julian date, which reflects the date of receipt for adjudication processing

Copayment	A monetary amount the member pays directly to a Health Plan at the time covered services are rendered
Cost Avoidance	The process of identifying and utilizing all sources of first or third-party benefits before services are rendered by the health plan or before payment is made by the health plan
Covered services	The health and medical services to be delivered by the health plan as described in Section 4 of the QI & CCS RFPs
Denials Report	The Denials Report is generated each encounter processing cycle and lists all encounters that deny
Dual Eligible	A member who is eligible for both Medicare and Medicaid
DHS	The State of Hawai'i Department of Human Services
Encounter	A record of a medically related service rendered by a registered MQD provider to a MQD member enrolled with a health plan on the date of service. An encounter is further defined as an inpatient or outpatient claim (837I); or each service line on a professional (837P) or pharmacy (NCPDP) claim
Encounter Adjudication Edits and Audits	MQD adjudication system for evaluating submitted encounter data for data quality problems and duplicate records
Encounter Form Type	The three encounter types are: • Professional services reported with an 837P (Form A / CMS 1500) • Pharmacy services reported with a NCPDP transaction (Form C) • Institutional services reported with an 837I (Form I or L or O / UB-04). Institutional encounters are further subdivided into three additional form types: Form Type I for inpatient hospital services; Form Type O for outpatient hospital services; and Form Type L for long-term care facility services.
Encounter Manual	Reference guide for health plans that are required to submit encounter data to MQD
HAWI	Hawaii Automated Welfare Information System
HCFA	Health Care Financing Administration
Health Plan	Health plans include medical and behavioral health plans contracted with the State of Hawaii to provide services to eligible members
HIPAA	Health Insurance Portability and Accountability Act

HPMMIS	The Hawaii Prepaid Medical Management Information System is based on the Arizona PMMIS and is operated and maintained by the State of Arizona for Hawaii
MQD	MQD is the Med-QUEST Division of the Hawaii Department of Human Services
PMR	Provider Master Registry; the monthly file MQD generates to inform the health plans of all providers known to MQD and their enrollment status
Provider	Any licensed or certified person or public or private institution, agency, or business concern authorized by DHS to provide healthcare, services, or supplies to MQD members
Reference Files	Files produced by MQD for health plans with information regarding service coverage
SFTP	Secure File Transfer Protocol (also known as SFTS – Secure File Transfer Server or EFT – Electronic File Transfer)
Subcontract	Any written agreement between the Health Plan and another party to fulfill the requirements of the health plan Contract.
Subcontractor	A party with whom the Health Plan contracts to provide services and/or conduct activities related to fulfilling the requirements of the health plan Contract.
TPL	Third Party Liability
TSN	Transmission Submitter Number; a number assigned by MQD for each submitter of encounter data. Health Plans must have one TSN and may have multiple TSNs.
Transaction Insight (TI) Encounter Validation /Translation Process	The MQD front-end editor validates syntax, code sets, and code relationships. Records that successfully pass validation are translated into file formats to be processed by the adjudication system.
VPN	Virtual Private Network

3. Overview

Each health plan is required to maintain and submit encounter data to the Med-QUEST Division (MQD) in accordance with the request for proposal contract and the Health Plan Manual.

All Professional and Institutional encounter data must be submitted in the HIPAA X12 837 format and must conform to the instructions outlined in the State of Hawaii Standard Companion Guide Transaction Information for Encounter Reporting.

All pharmacy encounter data must be submitted in the NCPDP format and must conform to the specifications outlined in the State of Hawaii NCPDP Post Adjudicated History (PAH) 2.2 Companion Guide.

3.1. Encounter Definition

An encounter is defined as a visit with a provider where one or more services may be incurred. It can entail the following examples.

- All services by one provider for one visit relative to a specific condition.
- A single physician visit for multiple conditions will be considered a single encounter.
- An inpatient encounter is defined as the entire hospital confinement or inpatient stay. All facility services incurred during the inpatient stay are part of the inpatient encounter, including the emergency room visit prior to and resulting in the hospital admission.

Encounters include all health care services provided to a member of which the plan is aware, regardless of whether the Medicaid financial liability.

- Health plans are responsible for reporting all encounters, including those listed below.
- Over-allowance services
- Excluded services
- Out-of-service area services
- Out-of-plan services
- Individual services reimbursed FFS under global fees and similar reimbursement schemes
- Actual service codes, even if down-coded for settlement purposes

3.2. Encounter Data Definition

CMS defines Encounter data as: “Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".”[1]

This includes information about the beneficiary, the provider(s), the diagnoses and procedures that were a part of a patient visit, and processing information about the provider's claim to the managed care health plan.

[1] https://www.cms.gov/glossary?term=encounter+data&items_per_page=10&viewmode=grid, accessed 11/26/2023

Encounter data is submitted in standard HIPAA transaction formats (837 and NCPDP) and must adhere to the requirements defined by both Centers for Medicare & Medicaid Services and the state.

3.3. Encounter Data Requirements

Health plans are required to submit encounter data for all valid Medicaid covered services, including encounters that are:

- Paid, including both fee for service (FFS), prospective payment system (PPS), capitated, and any other payment arrangements the plan may make with their providers
- Health plan denials for administrative reasons
- Zero Medicaid payment due to full reimbursement by another payer or bundling of services

The Health Plan shall submit all lines of a claim as a single encounter, thereby matching the structure of the claim to its resulting encounter.

MQD uses national industry standards and code sets as published by X12N, NCPDP, and other data standard maintenance organizations for encounter reporting. Refer to MQD's 837 and NCPDP Companion Guides for requirements health plans must follow in order to comply with contractual requirements.

In addition to the General Requirements outlined in the QI Contract section 6.4, the health plan shall ensure that submitted encounters meet, at a minimum, the following requirements:

- The member must be MQD eligible and enrolled with the health plan on the date of service as verified through the 834 file.
- The service provider must be actively registered with MQD on the date of service as verified through the PMR.
- The service must have been completed, and the provider's claim or encounter must be finalized as paid, administratively denied or zero Medicaid payment by the health plan before an encounter is submitted to MQD.
- The MQD Medicaid program is the payor of last resort. Medicare and other third-party payment must be accounted for prior to submitting the encounter. Medicare and third-party payment amounts must be entered on the encounter in the appropriate fields. In cases where a member has exhausted Medicare or other benefits or the service provided is not covered by another payor, the only fields necessary to populate are the Medicare or other insurance approved and paid amounts using a value of zero.
- If the health plan makes a post-payment/denial revision to a provider's claim after it has been submitted to MQD as an encounter, the health plan must resubmit appropriate void and replacement encounters to MQD.

3.4. Encounter Data Certification

To comply with 42 CFR Sections 438.604 and 438.608 the CEO, CFO or a direct report must certify encounter data prior to processing. By incorporating the attestation process noted below the Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to Chief Executive Officer or Chief Financial Officer, attests that the data and/or documents so recorded and submitted as input data or information, based on best knowledge, information, and belief, is in compliance with Subpart H of the Balanced Budget Act (BBA) Certification requirements; is complete, accurate, and truthful; and is in accordance with all Federal and State laws, regulations, policies and the Health Plan contract now in effect. If any of those procedures, rules, regulations, or statutes is hereafter amended, the Health Plan agrees to conform to those amendments of which Health Plan has been notified.

The Health Plan further certifies that it will retain and preserve all original documents as required by law, submit all or any part of same, or permit access to same for audit purposes, as required by the State of Hawai'i, or any agency of the federal government, or their representatives.

The BBA encounter attestation process for:

3.4.1. 837 Files

The Submitter Name Loop [1000A] allows for two repetitions of the PER segment. For the 837 attestation add one repetition of the PER Segment within the 1000A Submitter Name Loop. This allows the health plans to continue to submit a PER segment which indicates who to contact if a file has a problem.

For Example: The additional PER segment should be formatted as follows:

PER*EM*TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFI
LEISACCURATECOMPLETEANDTRUE.CERTIFIER@PLAN.COM*FX*602
5556789*TE*6025555678~

Where:

PER01 = IC - Information Contact

PER03 = EM - Electronic Mail.

PER04 = the attestation followed by the email address of the person who certifies the file, which must be compliant with BBA specifications

PER05 = FX - Fax Number

PER06 = The Fax Number of the person certifying the file

PER07 = TE - Telephone Number

PER08 = Telephone Number of the person certifying the file

3.4.2. NCPDP Files

An abbreviated attestation message is in the 35-character message field trailer record of the Batch 1.1 or 1.0 [the transport mechanism for the 5.1 and the 3.2 transactions].

For example:

"Attested John Doe CFO" (again, must be compliant with BBA specifications)

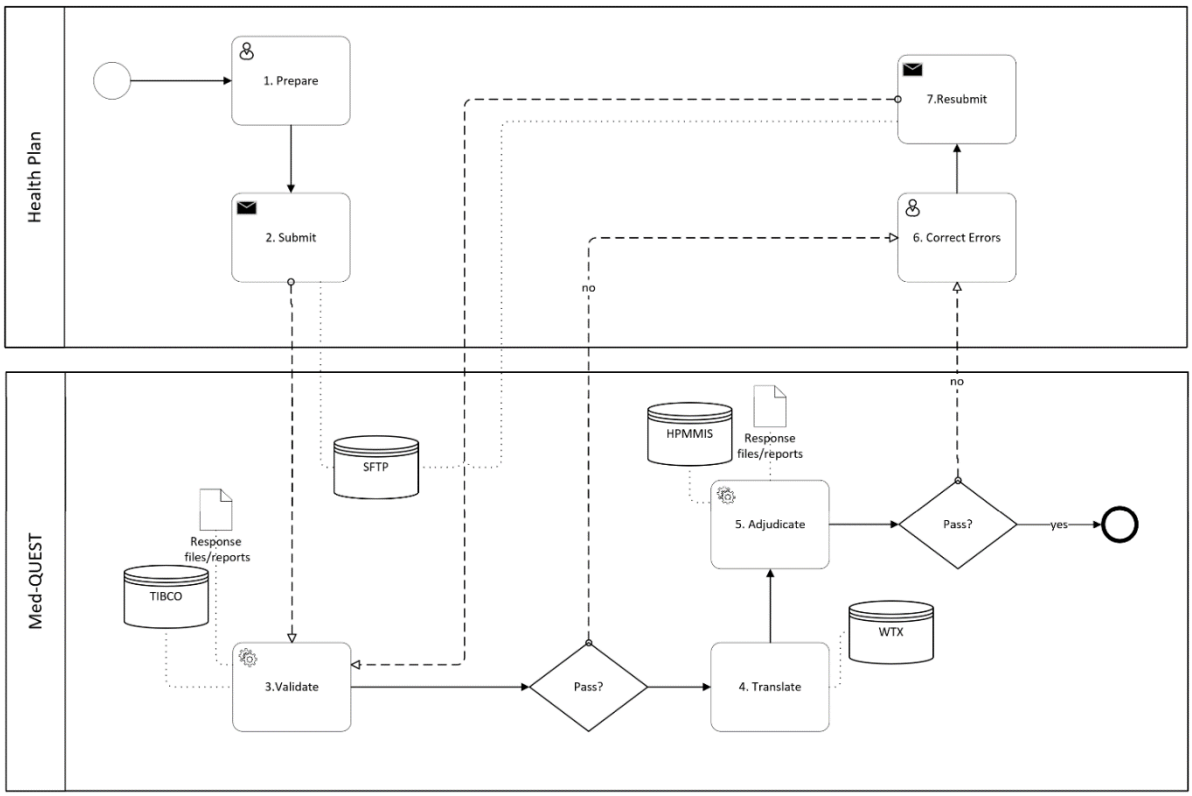
3.5. Encounter Data Use

As described in Section 6.4 of the QI Contract and 6.11 of the CCS Contract, MQD uses encounter data submitted by contracted health plans for a variety of purposes, including, but not limited to:

- Audits, investigations, identifications of improper payments and other program integrity activities
- Reporting and analysis, including federal reporting as described in 42 CFR §438.242(b)(1), policy analysis, executive and legislative decision-making, and research studies
- Capitation rate setting and risk adjustment, as well as hospital rate setting
- Calculation of pharmacy rebates
- Evaluation of managed care quality, utilization patterns, and access to care
- Verification of reported quality measure data prior to release of withhold or incentive payments

4. Process

The sections below includes both Health Plan steps and MQD steps for the Encounter Data Process at MQD.



Encounter Data Process

4.1. Prepare

Encounter data falls into the following categories:

- Professional – called Form Type A, reported using 837P
- Institutional – three form types, all reported using 837I:
    - Inpatient – Form Type I
    - Outpatient – Form Type O
    - Long-term Care – Form Type L
- Pharmacy – called Form Type C, reported using NCPDP

The following sections provide guidelines to categorize encounter data.

NOTE: Please review the Appendices for specific information related to Zero Pay encounters (6.2).

4.1.1. Professional

The professional encounter file (837p) should be used to report professional and other medical, dental, and behavioral services such as (note that this is NOT a complete list):

- Physician visits
- Nursing visits
- Surgical services
- Anesthesia services
- Laboratory tests
- X-rays
- Home- and community-based services
- Therapy services
- Durable medical equipment (DME)
- Medical supplies
- Transportation and taxi services
- Translation services

Services using this record type are typically associated with CMS 1500 claim forms or transportation claim forms. Another term for these files at Med-QUEST is Form Type A. A maximum of 999 detail lines can be submitted for each encounter.

For 837P file specifications, please see the 837 Companion Guide:
https://medquest.hawaii.gov/en/plans-providers/health-plan-resources.html

4.1.1.1. Health Plan Delivered Services/Plan Staff Services

The Health Plan shall create claims and submit encounter records for direct services rendered to beneficiaries by Health Plan personnel that may otherwise be delegable to providers in the community. Examples of such services include care coordination, service

coordination, housing coordination, case management, outreach efforts, medication reconciliation, and quality improvement activities.

For FAQs for Plan Staff Services, see Health Plan Staff Services FAQ -- Reporting_08172023.xlsx (sharepoint.com)

4.1.2. Institutional

Institutional encounters can be for:

- Inpatient (Form Type I)
- Outpatient (Form Type O)
- Long-Term Care (Form Type L)

4.1.2.1. Inpatient

The inpatient encounter should be used to report facility services such as inpatient hospital and institutional services. Inpatient services that are usually reported on UB-04 claim forms or other institutional claim forms are to be reported in the 837 Institutional (837I) encounter file.

For 837I file specifications, please see the 837 Companion Guide: https://medquest.hawaii.gov/en/plans-providers/health-plan-resources.html

A maximum of 999 detail lines can be submitted for each encounter of this record type.

4.1.2.2. Interim Inpatient Stays

Health plans should not hold interim inpatient encounters until the final bill representing discharge has occurred. Instead, the interim inpatient encounters can be submitted without delays, but must represent the complete inpatient stay to date.

4.1.2.2.1. Separate Admissions

As one of the Medicaid HEDIS measures for utilization, clarification of facility transfers or changes in level of care is warranted for the accuracy of the admission and transfer data.

The following situations of continued inpatient care would require submission of separate admission encounter data.

- Transfers between inpatient care institutions or facilities
- Transfers between acute and non-acute facilities (skilled nursing facility, sub-acute, waitlisted for LTC or intermediate nursing facility)
- Transfer between inpatient psychiatric and residential facilities

Note: Changes in acute levels of care are not separate admissions. The levels of care in an acute medical facility are acute care, intensive care (ICU), and cardiac care (CCU).

4.1.2.2.2. Diagnosis Related Groups

Health Plans shall follow specific submission guidelines for encounters meeting criteria for APR-DRG posted on the MQD website: https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html

4.1.2.3. Outpatient

Outpatient encounter record should be used to report medical-facility-based outpatient services, such as hospital emergency room, DME, Hospice, Home Health, diagnostic services provided by facilities, and dialysis services. Outpatient services that are usually reported on UB-04 claim forms or other institutional claim forms are to be reported in the 837 Institutional (837I) encounter file.

Also, to be reported on this record type is ancillary services for long-term care, sub-acute and waitlist levels of care.

For 837I file specifications, please see the 837 Companion Guide: https://medquest.hawaii.gov/en/plans-providers/health-plan-resources.html

A maximum of 999 detail lines can be submitted for each encounter of this record type.

4.1.2.4. Long-term Care

[Placeholder for future guidance]

4.1.3. Pharmacy

The drug encounter record should be used to report NDC-identified drug and medical supplies services dispensed by an outpatient pharmacy, other than inpatient pharmacy. All pharmacy encounters must be submitted in the NCPDP file format.

4.2. Submit

Encounter data reporting for medical services provided to eligible members are submitted electronically by health plans to HPMMIS using the HIPAA 837 file format. This section describes the submission phase of the Encounter Data process.

4.2.1. Schedule

A health plan can submit its encounter information electronically to the MQD on a daily basis, however the plan must submit no later than the last day of the month. The health plan is required to submit data every month.

4.2.2. Formats

All Professional and Institutional encounter data must be submitted in the HIPAA 837 format and must conform to the instructions outlined in the State of Hawaii Standard Companion Guide Transaction Information for Encounter Reporting.

All pharmacy encounter data must be submitted in the NCPDP format and must conform to the specifications outlined in the State of Hawaii NCPDP Post Adjudicated History (PAH) 2.2 Companion Guide.

4.2.3. Method

DHS requires health plans to submit encounter data electronically using the SFTP standard over a secure Internet connection. The use of any other method is not acceptable.

4.2.3.1. SFTP

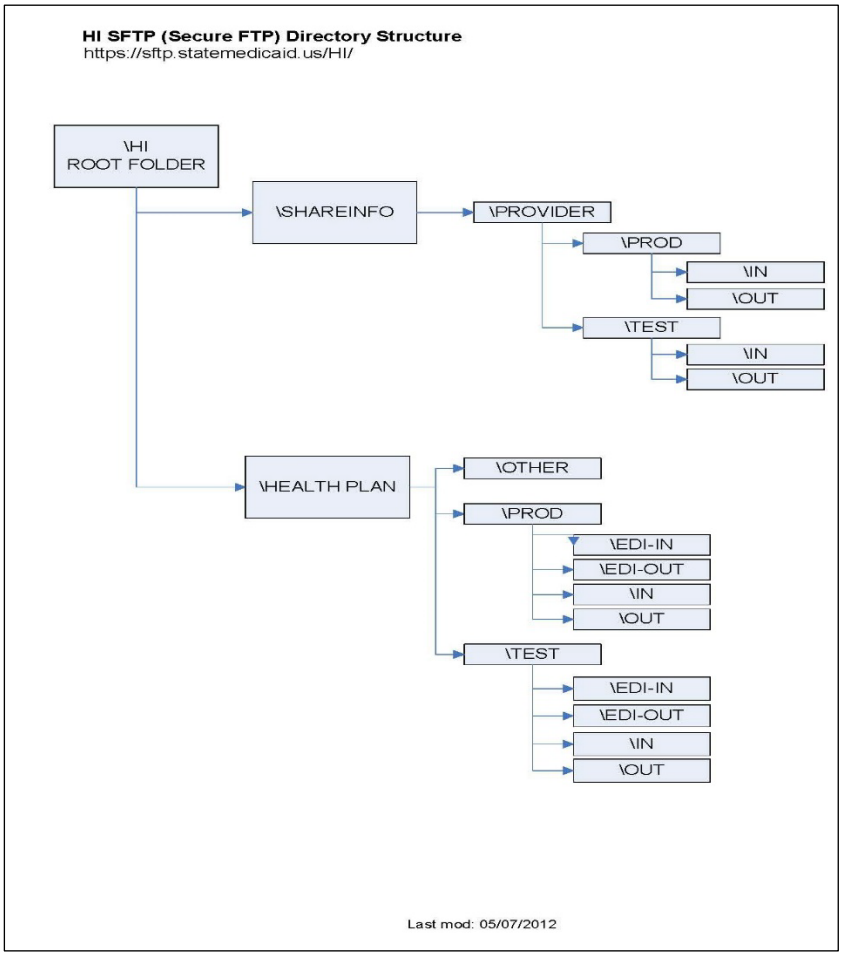
The SFTP (Secure File Transfer Protocol) is the source of all file transfers between the MQD and the health plans. The SFTP accepts a standard web browser via Hypertext Transfer Protocol over Secure Socket Layer (HTTPS) and File Transfer Protocol (FTP) over Secure Shell (SSH) SFTP.

The SFTP is available 24 hours a day, seven days a week. Information on when encounter files should be submitted is available in this manual. Please refer to the appropriate section.

An Electronic Data Request form along with instructions will be made available to Health Plans in order to receive access to the SFTP. A health plan can request a service account which is used for automated processes as well as individual logon access. There will no longer be a generic logon account for each health plan.

4.2.3.2. Directory Structure

The directory structure for the SFTP is in the diagram below:



Folder Descriptions

Folder Name	Contents
ShareINFO	Files which do not contain HIPAA data and can be shared with all health plans will be placed under this folder.
OTHER	The OTHER folder will be used to transmit miscellaneous files or reports between MQD and health plans.
PROD	Data files placed/retrieved from the sub folders under the PROD folder will be processed by HPMMIS and should be processed by the health plans to meet their contractual obligations. Encounter production files should be placed in the EDI-IN subfolder. Encounter 837 response files from our Validator as well as the 277U file will be placed in the EDI-OUT subfolder. The encounter proprietary output files and reports will be placed in the OUT subfolder.
TEST	The Test folder will be used for testing changes that the MQD or health plan may need. Encounter test files should be placed in the EDI-IN subfolder. Encounter 837 response files will be placed in the EDI-OUT subfolder. The .241, .947 and .179 files will be placed in the OUT subfolder. The encounter test cycle runs twice a week, early Tuesday and Friday mornings. Please submit your test files the day prior to the test cycle. If you want to have your test files processed on another day, please submit your files by 11:30 am HST on that day and email the Systems Office to request that a special encounter test cycle be run. There may be times when the encounter cycle will temporarily need to be run several times a week due to a special implementation project. The Systems Office will then notify the health plans of the timeframe of these special cycles.

4.2.3.3. Filenames

Files will be sent and received by health plans using the naming conventions listed in the table below.

- Filenames for the 837 submissions will be 20.3 where the first two characters identify the health plan; characters 3-10 the date the file was generated; characters 11-19 the Interchange Control Number found in segment ISA13 (9 digits long, must be zero-filled); character 20 is the form type (P or I).
- Filename for the NCPDP submission will be 16.3 where the first two characters identify the health plan; characters 3-7 will be 'NCPDP'; characters 8-15 will be the date the file was generated; character 16 will be an alpha beginning with A and incrementing to Z if there are multiple NCPDP file submissions for the same date.
- Filenames for the 241, 947 and 179 encounter files will continue to be 10.3 where the first two characters identify the health plan; characters 3-10 is the date of the cycle run. The extensions to these files are listed in a separate column below.

Filenames and Extensions

Submissions/Returns	Filename	Extension
837 Professional Encounters Paid	XXYYYYMMDDICNP	.TXT

Submissions/Returns	Filename	Extension
837 Professional Encounter Denials	XXYYYYMMDDICNP	.DENY
837 Institutional Encounters Paid	XXYYYYMMDDICNI	.TXT
837 Institutional Encounter Denials	XXYYYYMMDDICNI	.DENY
NCPDP (Pharmacy) Encounters Paid	XXNCPDPYYYYMMDDA	.TXT
Encounter Error Report (241)	XXYYYYMMDD	.241
Hawaii Cycle Encounter Report (ECHAR947)	XXYYYYMMDD	.947
Duplicate ERI by Error Code Report (ECHAR179)	XXYYYYMMDD	.179

4.3. Validate

After being received by SFTP encounters are first edited by the Validator utilizing the HIPAA rules.

NOTE: These are not the same as the edits that are applied during adjudication.

The NCPDP (pharmacy) encounters will go through minimal edits including checking the record length and validating the counts and amounts in the trailer record. If there is an error, the entire NCPDP file will reject and no pharmacy encounters will be loaded to the mainframe staging database.

4.3.1. HIPAA Level Edits

These are SNIP Level Validation and Edits, which refers to the Strategic National Implementation Process (SNIP), designed by the Workgroup for Electronic Data Interchange (WEDI). SNIP includes seven levels for industry-standard levels of verification when it comes to electronic data compliance. These edits ensure that the encounter files are correctly formatted and adhere to the rules defined in the X12 HIPAA EDI standards. Med-QUEST CEDQI project - EDI - All Documents (sharepoint.com)

The Validator performs edits for the following SNIP levels:

TRANSACTION & CODE SETS TESTING TYPES

Testing Type	Description
1	EDI Syntax Integrity Testing – Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of ANSI X12, and compliance with ANSI X12. This will validate the basic syntactical integrity of the EDI submission. Example: Paired conditional “if this is present, then that is required” intra-segment.

2	HIPAA Syntactical Requirement Testing – Testing for X12 Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. Also included in this type is testing for HIPAA required or intra-segment situational data elements, testing for non-medical code sets as laid out in the Implementation Guide, and values and codes noted in the Implementation Guide via an ANSI X12 code list or table. Example: Value = Y (Yes) or N (No).
3	Balancing Testing - Testing the transaction for balanced field totals, financial balancing of claims and/or remittance advice, and balancing of summary fields, if appropriate. Must have Level 1 and Level 2 with a Level 3.
4	Situation Testing – The testing of specific Inter-segment situations described in the HIPAA implementation guides such that: If A occurs, then B must be populated. This is considered to include the validation of situational fields given values or situations present elsewhere in the file". Example: If the transaction is an inpatient claim, a date of admission must be present.
5	External Code Set Testing - Testing for valid implementation-guide-specific code set values and other code sets adopted as HIPAA standards. This level of testing will not only validate the code sets but also make sure the usage is appropriate for any particular transaction and appropriate with the coding guidelines that apply to the specific code set. Examples: CPT, CDT3, NDC, ICD9, ZIP Codes, etc.
6	Product Types or Line of Services Testing (also known as line-of-business testing) - Specialized testing required by certain healthcare specialties, such as chiropractic, ambulance, durable medical equipment, etc. This testing type is required to ensure that the segments/records of data that differ based on certain healthcare services are properly created and processed into claims data formats. These specific requirements are described in the Implementation Guides for the different product types or lines of service. This type of testing only applies to a trading partner candidate that conducts transactions for the specific line of business or product type. Example: "Required on all ambulance claims/encounters when the patient was known to be admitted to the hospital. Also required on inpatient medical visits claims/encounters.

7	Trading Partner-Specific Testing – The Implementation Guides contain some HIPAA requirements that are specific to Medicare, Medicaid, and Horizon. Compliance or testing with these payer specific requirements is not required from all trading partners. If the trading partner candidate intends to exchange transactions with one of these Implementation Guide special payers, this type of testing is required. When a certification service certifies a trading partner for compliance, the certification service must indicate whether these payer specific trading partners may have their own specific business requirements; but, unless they are listed in the X12 Implementation Guides, they are not HIPAA requirements. These non-HIPAA trading partner specific requirements must be tested as part of the business-to-business testing. Examples: Edits for Medicare, Medicaid, or Indian Health Services.

S/HIPAA/Transaction Edit Docs/TESTING LEVELS-TYPES description.doc

4.3.2. Response Files

Validation generates various response files, which are sent back to the Health Plan.

4.3.2.1. Acknowledgement- TA1

A TA1 file will be generated if there was a problem with the ISA/IEA Interchange Envelope (usually an Invalid Test/Prod indicator, Invalid Sender, or Duplicate ISA) and the entire 837 encounter file will not continue into our mainframe staging database.

4.3.2.2. Acknowledgement – 999

The encounters that are rejected (do not pass HIPAA level 1 and 2 validation) will be reported in the 999 acknowledgement file and will not continue into our mainframe staging database. If there are no rejected encounters, an 999 acknowledgement file will still be generated to report that the file was accepted.

4.3.2.3. Acknowledgement – 824

The encounters that are rejected (do not pass HIPAA level 3-7 validation) will be reported in the 824 acknowledgement file and will not continue into our mainframe staging database.

4.3.2.4. Acknowledgement- 277CA

A 277CA (Claims Acknowledgement) file will be generated for every 837 file and will contain all encounters from that file with an Accepted or Rejected status.

4.3.3. For Validator Assistance

If assistance is needed from the MQD Systems Office to troubleshoot an encounter that was rejected by the Validator, please provide the following information:

- 837 filename
- Patient Account Number (PAN)
- Error message that was reported by the Validator (including whether the error came from the 999 or 824 file)

4.4. Translate

Encounters that are accepted (pass validation) will be translated into "machine language" and continue into our mainframe staging database and be placed in a Wait status for the next encounter cycle.

4.5. Adjudicate

Encounter submissions that pass the Validation process are accepted and loaded into the HPMMIS database. Accepted submissions are processed through the full range of edits/audits during the encounter processing cycle. Currently pended encounters will automatically be reprocessed through the full range of edits/audits as well.

All encounter files will be adjudicated bi-monthly in HPMMIS on the 1st and 3rd Wednesday of each month. To be included in a particular adjudication cycle, an encounter file must be submitted no later than 5:00 p.m. HST on the Tuesday prior to a processing Wednesday. DHS has the right to change the encounter-reporting deadline with 60 days advance notification to the health plans.

During the encounter cycle, all encounters that pass the editing/auditing process will be accepted as adjudicated or approved encounters. All other encounters that have not passed the edits/audits processing will be committed to the database as pended or denied. Pended and denied encounters will be reported to the health plans via the .241 Encounter Input Error Detail Report, for correction and resubmission. The record layout for the .241 file is located below in the Encounter Input Error Detail (241) section.

4.5.1. Edits

HPMMIS has a set of encounter edits that are set to either Pend, Deny or Off. Health plans receive pended and denied encounters via the .241 Encounter Input Error Detail Report.

Edit Status Codes	The value of this field in the table determines whether an edit is applied or not and at what level of severity
D	On: **Deny** – If the data in an encounter meets the logic for this edit status, that encounter will be denied and sent back to the plan. This status is for data that is so wrong it must be corrected to be usable.
N	**N = Off** – This means that an edit is not turned on. Even if the data in an encounter meets the logic, the encounter will still be accepted, because the edit itself is not activated.

P	On: **Hard Pend**, Developer Only – This pends encounters so that AZ/HI staff can review the encounter and either maintain or override the pend, depending on business need.
S	On: **Soft Pend** –This accepts the record with a warning message.
Y	On: **Hard Pend**, Permissions Granted – This pends encounters so that entities with permission can review the encounter and either maintain or override the pend, depending on business need. These permissions are not granted for HI plans.
Null	The data **element does not exist** on that form type. It cannot be set to a status because it is not there.

Two edits that health plans frequently ask questions about are H270 (PRIOR CRN NOT FOUND OR MISMATCHED) and H280 (ORIGINAL ENCOUNTER NOT ELIGIBLE TO ADJUST)

H270 occurs when a health plan sends a Replacement or Void and the Orig CRN the health plan reported is not found in HPMMIS.

H280 occurs when a health plan sends a Replacement or Void and the Orig CRN is found in HPMMIS but the Orig encounter is already Replaced or Voided. If health plan encounters incur this edit code, it will appear in the .241 file during the encounter processing cycle in which it occurred:

'QUEST Error Code' field will have either H270 or H280

'Field Identifier' field will have "DNL"

'Error Message' field will start with "DENIED" followed by either "PRIOR CRN NOT FOUND OR MISMATCHED – RESUBMIT" for H270 or "ORIGINAL ENCOUNTER NOT ELIGIBLE TO ADJUST – RESUBMIT" for H280.

If H270 or H280 do not appear in you're the .241, that means no encounter logged these errors in the current cycle.

4.5.2. Duplicates

For the purpose of establishing the existence of a duplicate record, the following will be checked:

- All records from the same submission that have already been adjudicated or pended, AND
- All records currently on file in the HPMMIS system that were previously adjudicated or are currently in a pended status.

4.5.2.1. Pharmacy

The record will be identified as a duplicate when all of the following fields from two or more records (either being submitted, adjudicated, or pended) match exactly:

- Cardholder ID
- Service Provider ID
- Date of service (Dispense Date)
- Full 11 digits of the Product/Service ID (NDC)

- Units
- Billed Amount

4.5.2.2. Institutional

The record will be identified as a duplicate when all of the following fields from two or more records (either being submitted, adjudicated, or pended) match exactly:

- HAWI ID
- Provider ID
- Bill type:
    - Facility Type Code (1st and 2nd positions)
    - Claim Frequency Code (3rd position)
- Total Claim Charge Amount
- Service Date

4.5.2.3. Professional

The record will be identified as a duplicate when all of the following fields from two or more records (either being submitted, adjudicated, or pended) match exactly:

- HAWI ID
- Provider ID
- Procedure Code (HCPCS Code)
- Procedure Modifier
- Procedure Modifier 2
- Procedure Modifier 3
- Procedure Modifier 4
- Primary Diagnosis Code
- Service Begin Date
- Service End Date
- Units
- Billed Amount

4.5.3. Reports

The file formats in this section are used to communicate encounter information between MQD and the health plans.

Encounter Input Error Detail (241)

File Header Record Format

#	Data Element Name	Size	Type	Description
1	Health Plan	6	AN	Health Plan ID

2	Current Date	8	N	CCYYMMDD
3	File Type Code	2	AN	EN = Encounter

QUEST Encounter Input Error Detail Report (EN000241)

				Actual Position		
#	Data Name	Size	Type	From	To	#
1	Health Plan ID	6	AN	1	6	1
2	CRN	15	AN	7	21	2
3	Encounter Record ID	20	AN	22	41	HP assigned unique encounter record number (for encounters processed prior to 7/1/12)
4	HP Claim ID	20	AN	42	61	Health plan assigned identifier used to link to the health plan's internal system (for encounters processed prior to 7/1/12. Effective 7/1/12, the HP Claim ID is found in the 277U file).
5	Encounter Detail Number	5	N	62	66	HP assigned number uniquely identifying a record within the encounter
6	HAWI Client ID	10	AN	67	76	HAWI assigned client identification number
7	QUEST Error Code	4	AN	77	80	QUEST assigned error code
8	Field Identifier	3	AN	81	83	Identifies the field in the encounter where the error occurred
9	Error Message	100	AN	84	183	Description of the error

File Trailer Record Format

#	Data Element Name	Size	Type	Description
1	Trailer Indicator	6	AN	ZZZZZZ
2	Current Date	8	N	CCYYMMDD
3	Total Count	6	N	Total number of records (including header and trailer

4.5.3.1. Duplicate CRN by Error Code (179)

For all "Exact Duplicate Found" edits, this report lists the CRNs along with the related HP Claim Number, Patient Account Number, Form Type, HAWI ID, Provider NPI and Service Begin and End Dates. The report will contain all duplicates from new submissions for the current cycle only.

```
 1REPORT ID: EC97R179-Health Plan ID            HAWAII DHS MED-QUEST DIVISION HPMMIS                                PAGE:      1
 PROGRAM #: EC97L179                               DUPLICATE CRN BY ERROR CODE                                      RUN:06/21/12

                                                          AS OF 06/21/12
0TAPE SUPPLIER ID: 99                                                          2ND LINE: IN-PROCESS DATA / 3RD LINE: HISTORICAL DATA

   HEALTH PLAN ID: HP ID                                                       **************************************************

            CRN             HP CLAIM NUMBER               PATIENT ACCOUNT NO   HP ID  BEGIN DATE  END DATE  F PROVIDER      HAWI ID
                                                                                                                ------------
 Z720  EXACT DUPLICATE FOUND
                                                          12345678             HP ID  02/13/2012 02/13/2012 A 1234567890 000123456
            999999999999001 12345678                                                 02/13/2012 02/13/2012 A 1234567890 000123456
            ..................
```

4.5.3.2. Cycle Encounter Report (947)

This monthly report shows a health plan's number and percentage of encounters for a calendar year by month, and a year to date total for encounters that are adjudicated, pended, denied or voided.

Term	Definition
Adjudicated Encounters	New encounters which were processed according to the policies and procedures of MQD and were determined to be valid.
Pended Encounters	New encounters which were processed according to the policies and procedures of MQD and did not pass the edits and audits processing.
HP Denied & Adjudicated	New encounters that were submitted in the .DENY file and were determined to be valid according to the policies and procedures of MQD.
HP Voided & Adjudicated	Encounters that were submitted with a Claim Frequency Code of '8', and were determined to be valid according to the policies and procedures of MQD.

Term	Definition
**CM Total	Cumulative total of encounters processed over a specified period

REPORT ID: ECHAR947 HAWAII CYCLE ENCOUNTER REPORT PAGE: 1

PROGRAM #: ECHAL947 RUN:02/07/2003 18:06

AS OF 02/07/2003

HEALTH PLAN ID: ANY HEALTH PLAN ANYHEALTHPLAN - MEDICAL

RUN DATE	FORM TYPE	ADJUDICATED ENCOUNTERS #	%	PENDED ENCOUNTERS #	%	HP DENIED & ADJUDICATED #	%	HP VOIDED & ADJUDICATED #	%	TOTAL ENCOUNTERS PROCESSED #	%
02/07/2003	HCFA 1500	0	.00	0	.00	0	.00	0	.00	0	.00
	UB-92	0	.00	0	.00	0	.00	0	.00	0	.00
	PHARMACY	0	.00	0	.00	0	.00	0	.00	0	.00
	DENTAL	0	.00	0	.00	0	.00	0	.00	0	.00
	TOTAL	0	.00	0	.00	0	.00	0	.00	0	.00
	**CM TOTAL	0	.00	0	.00	0	.00	0	.00	0	.00
001/04/2003	HCFA 1500	0	.00	0	.00	0	.00	0	.00	0	.00
	UB-92	0	.00	0	.00	0	.00	0	.00	0	.00
	PHARMACY	0	.00	0	.00	0	.00	0	.00	0	.00
	DENTAL	0	.00	0	.00	0	.00	0	.00	0	.00
	TOTAL	0	.00	0	.00	0	.00	0	.00	0	.00
	CM TOTAL	0	.00	0	.00	0	.00	0	.00	0	.00
012/06/2002	HCFA 1500	0	.00	0	.00	0	.00	0	.00	0	.00
	UB-92	0	.00	0	.00	0	.00	0	.00	0	.00
	PHARMACY	0	.00	0	.00	0	.00	0	.00	0	.00
	DENTAL	0	.00	0	.00	0	.00	0	.00	0	.00
	TOTAL	0	.00	0	.00	0	.00	0	.00	0	.00
	CM TOTAL	0	.00	0	.00	0	.00	0	.00	0	.00

4.5.3.3. Unsolicited Encounter Status Transaction (277U)

All processed encounters will appear in the 277U file from the current encounter cycle. Refer to the 277U Companion Guide for more information on this file.

4.5.4. For Adjudication Assistance

If assistance is needed from the Systems Office to troubleshoot a pended encounter that appeared in the 241 file, please provide the following:

- Error code and description from the 241 file
- CRN of the encounter
- Reason encounter should not have pended

4.6. Correct Errors

[Placeholder for future guidance]

4.7. Resubmit

[Placeholder for future guidance]

5. Data Quality

The RFP requires that Health plans submit accurate, complete, and timely data to DHS. In 2022, the Healthcare Analytics Office (HAO) created a multi-dimensional definition of data quality. This definition allows MQD staff, staff from Health Plans, and contractors to discuss and work on data quality issues and improvement, with mutual understanding of what is meant by the term "data quality".

Including multiple dimensions in a data quality definition is common across many industries and academic explorations of this topic because there are many aspects of data that could be of high or low quality, and we need to keep all of those in mind as we seek to improve the quality of our data at MQD. Calling out the multiple dimensions in our data quality definition:

- Provides a framework to focus efforts for data quality improvement
- Ensures that data quality is measured and quantified across all the dimensions
- Ensures that efforts to improve one dimension of data quality do not inadvertently damage other dimensions of data quality

There are many possible combinations of data quality dimensions in use today. The five dimensions selected for the MQD data quality definition were chosen to be appropriate to MQD's particular circumstances and needs. Data must satisfy all five dimensions to meet the definition of high-quality data. The dimensions are:

- Completeness
- Validity
- Timeliness
- Plausibility

- Accuracy

Each of these dimensions are described in detail in the following sections.

5.1. Definition

Keeping in mind the goal of being able to use correct data to understand what is happening in the real world and make decisions accordingly, MQD uses the following definition of high-quality data:

Data represents real-world entities and events. High quality data must represent these entities and events correctly. Therefore, high quality data must be complete, valid, timely, plausible, and accurate.

5.1.1. Completeness

Data is complete when it includes all of the events or entities in the real world that the data describes, and only includes those. The two ways that data can fail to meet completeness are:

- The data does not include every real-world event or entity that it should (missing data)
- The data includes records that do not match a real-world event or entity (surplus data)

For example, if a managed care beneficiary sees a provider, but this is not reported in the encounter data, this is missing data. If there are encounters that do not match a unique real-world interaction with a provider (due to duplication, or erroneous reporting, or fraud, etc.), this is surplus data.

5.1.2. Validity

Data is valid when both the structure and contents of the data correctly match the standards and formats used for the data. The two ways that data can fail to meet validity are:

- There are extra, missing, or garbled data elements in a record (invalid at record level)
- There are data elements that do not comply with required standards and formats (invalid at data element level)

For example, if an encounter record for a professional visit is missing a procedure code, it is invalid at the record level. If an encounter has a value in the procedure code data element, but it is not a valid procedure code (not in the list of valid HCPCS codes), it is invalid at the data element level.

NOTE: a ‘valid’ code is a code that can be found on the appropriate list of valid values. An invalid code is one that is not a valid code. A valid code may be inappropriately used, according to business rules, but that is a compliance issue, not a data validity issue. For example, if a provider sends an encounter with a procedure code value of ‘PROC1’, that is invalid (because it is not on the list of valid HCPCS codes). But if a podiatrist sends a procedure code of 61323 (a valid HCPCS code for ‘Under Craniectomy or Craniotomy Procedures’), that may be inappropriate (a podiatrist should not be sending craniectomy codes), but it is not an invalid code. Please see “Data Quality vs. Compliance Monitoring” below for more discussion of the difference between data quality and compliance.

5.1.3. Timeliness

Data is timely when there is a short lag between the event it portrays and its availability for use. The two ways that data can fail to meet timeliness are:

- There is an excessive lag time between the occurrence of the event and the data about the event being sent to MQD (excessive external lag time)
- There is an excessive lag time between the time MQD receives the data and the time when the data is made available for use (excessive internal lag time)

For example, if a patient visit occurs on January 1, 2022, and the plan does not send an encounter associated with this visit to MQD until December 15, 2022, this is excessive external lag time. If MQD receives an encounter on January 1, 2022, but does not make it available for use until December 15, 2022, this is excessive internal lag time.

5.1.4. Plausibility

Data is plausible when statistical analyses of the whole data set are reasonable. (Would a reasonable person, familiar with health care data, accept this? Does it pass 'the laugh test'?) Data fails to meet plausibility when the data set as a whole is not reasonable, even if individual records are each reasonable.

For example, if every encounter record from one health plan in a single month included a secondary diagnosis of diabetes, that would be implausible – even if each individual record passed all edits and checks.

5.1.5. Accuracy

Data is accurate when it matches the real-world event or entity it purports to describe. Data is inaccurate when it does not correctly describe the real-world event.

For example, if a procedure is performed on a patient's right hand, but the encounter data indicates that it was on the left hand, that data is inaccurate.

5.2. Data Quality vs. Compliance Monitoring

It is important to note that data quality does not equate to compliance with MQD policy. High quality data may show examples where plans or activities are out of compliance with MQD policy and low-quality data may obscure non-compliance, when it is happening.

Data describes something in the real-world. For example, encounter data describes interactions between patients and providers; grievance data describes complaints members have made with health plans. Discussions of data quality should focus on whether we can rely on the data to actually describe a real-world event. Discussions about the appropriateness of the real-world event or whether the real-world event complied with MQD policy are separate issues from data quality.

For example, imagine a plan submits encounter data that shows MQD members were seen by providers who are barred from participation in the program. If this is actually what happened, it is not a data quality issue, but a policy compliance issue. This policy compliance issue should not trigger edits designed to ensure high data quality because the data submitted by the plan is high quality. We can use it to understand the real-world event it purports to represent. In a claims processing environment (such as the Fee-For-Service program), a similar claim would be denied. However, for encounter data that has already

been adjudicated by the health plan before being submitted to MQD, the data is intended to help MQD know what is happening. Editing or pending this data impedes actually complicates and limits MQD's ability to take appropriate action to address the issue with non-compliance.

5.3. Liquidated Damages

Health Plans shall adhere to the requirements set forth in QI Contract Section 6.4 (CCS Contract Section 6.11) for submitting timely, accurate, and complete data. MQD measures these requirements through a set of tools described below and may assess liquidated damages when encounters do not meet the requirements.

5.3.1. Completeness Measurements

MQD measures completeness through the following measures:

Measurement Name	Measurement Tool	Measurement Specification	Appendix G #	Penalty
Completeness Attestation	837I, 837P, NCPDP Certification (Section 2.4)		18	Up to $10,000.00 per file and an additional penalty of $1,000.00 per each late day beyond the thirty (30) days of notification.
Magic File				
Submission Reconciliation Form (SRF)	SRF form (Excel template submitted monthly by health plans)	Comparison of health plans' perceived submitted encounter files with MQDs received encounter files		

5.3.2. Validity Measurements

[Placeholder for future guidance]

5.3.3. Timeliness Measurements

MQD measures timeliness through the following measures:

Measurement Name	Measurement Tool	Measurement Specification	Appendix G #	Penalty
Minimum Monthly Submission	Submission Reconciliation Form (SRF)	Must submit encounter data on a monthly basis	17	$50,000 per file per type (837I, 837P, NCPDP)
Days from Financial Liability Assessed	DQM		16	$5,000 per encounter per day late
Days from Date of Service	DQM		16	$5,000 per encounter per day late

5.3.4. Plausibility Measurements

MQD measures plausibility through the following measures:

[Placeholder for future guidance]

5.3.5. Accuracy Measurements

MQD measures accuracy through the following measures:

Measurement Name	Measurement Tool	Measurement Specification	Appendix G #	Penalty
Accuracy Attestation	837I, 837P, NCPDP Certification (Section 2.4)		18	Up to $10,000.00 per file and an additional penalty of $1,000.00 per each late day beyond the thirty (30) days of notification.

6. Contacts

For questions relating to encounter data submission, please send an email to mqd-encounters@dhs.hawaii.gov.

To report problems, please send an email to mqdhelpdesk@dhs.hawaii.gov.

If you have any questions, please call the following personnel.

Topic	Contact Person
All Systems	MQD Help Desk 808-692-7952 or Webex (808) 900-6020
Encounter	Wileen Ortega 808-900-6024
Provider	Wileen Ortega 808-900-6024
Health Plan & Rosters Questions	Haidee Shaw 808-692-7963
VPN, Connectivity to MQD FTP, Logons	Network Support 808-692-7952

For calls reaching Systems Office Staff voicemail, a customer can leave a message or press "03" and the call will be transferred to the MQD Help Desk for assignment. If you get the Help Desk voicemail, please leave a message and a SO staff member will return your call within 2 hours (during normal business hours).

7. Appendices

The following Appendices are included for reference.

7.1. Health Plan Filename Identifiers, Health Plan Codes and Health Plan TSN (Tape Supplier Name)

837 filenames will follow a 20.3 format with alphanumeric characters. NCPDP filenames will follow a 16.3 format with alphanumeric characters. Each health plan has been assigned a two-character health plan identifier for the purpose of naming files. The plan identifiers are:

Health Plan Filename Identifiers

Health Plan	ID
AlohaCare - non-ABD clients	AM
AlohaCare - ABD clients	XA
HMSA - non-ABD clients	HM
HMSA - ABD clients	XH
Kaiser - non-ABD clients	KM
Kaiser - ABD clients	XK
Ohana (Wellcare) - non-ABD clients	HQ
Ohana (Wellcare) - ABD clients	XO
Ohana (Wellcare) - Behavioral Health	OB
UnitedHealthcare - non-ABD clients	IQ
UnitedHealthcare - ABD clients	XU

Health Plan Codes

Plan Code	Health Plan
ALOHAC	AlohaCare - non-ABD clients
XALOHA	AlohaCare - ABD clients
HMSAAA	HMSA - non-ABD clients
XHMSAA	HMSA - ABD clients
KAISER	Kaiser - non-ABD clients
XKAISR	Kaiser - ABD clients
OHANAA	Ohana (Wellcare) - non-ABD clients
XOHANA	Ohana (Wellcare) - ABD clients
OHANBH	Ohana (Wellcare) - Behavioral Health
UNITED	UnitedHealthcare - non-ABD clients
XUNITD	UnitedHealthcare - ABD clients

Health Plan TSN (Tape Supplier Name)

Plan Code	TSN
ALOHAC	001
XALOHA	024
HMSAAA	006
XHMSAA	025
KAISER	009
XKAISR	026
OHANAA	022
XOHANA	016
OHANBH	021
UNITED	023
XUNITD	020

NOTE: ABD = Aged, Blind, Disabled

7.2. Health Plan "Zero Pay" Encounters

Zero Pay encounters are encounters for which the Health Plans did not deny the claim but paid zero due to one of the following scenarios:

A claim was denied by the health plan for administrative reasons

A non-fee for service payment arrangement, such as sub-capitation or prospective payment system (PPS)

The claim involved a coordination of benefits where no payments were made under Medicaid by the health plan assessing financial liability

The following sections provide guidance for submitting zero-pay encounters.

> **NOTE**: Zero Pay encounters *do not* include scenarios where services are not paid due to bundled payment arrangements. For information on submitting these types of encounters. Further guidance is forthcoming.

7.2.1. Health Plan Administrative Denied

Health Plan Administrative Denials encounters are defined as Health Plan adjudicated claims that have been denied or non-covered in full for only specific types of administratively related reasons. Denials for administrative reasons represent those claims which are for valid Medicaid covered services provided to eligible members, by enrolled and eligible providers that were denied by Health Plans for administrative issues such as:

- Failure of the provider to obtain a required Prior Authorization (PA)
- Untimely submission of the claim to the Health Plan
- Provider billed units are in excess of Medicaid service benefit limits
- Provider's failure to supply required claims supporting documentation

Plans should submit these encounters in .deny file and use the following, depending on the type of encounter:

Encounter Type	Process
Professional	For Professional encounters, the denied and paid lines must be separated and reported in separate Paid and Denied (.DENY) files. To link the separated encounter, the same Patient Account Number (PAN), used in 2300/CLM01, can be submitted in both files.
Institutional	For Institutional Encounters, if the claim was denied at the header level the entire Health Plan Denied encounter should be submitted in the Denied (.DENY) file. If the claim was accepted, but contains some lines that were Health Plan Denied and some lines that were Paid, do not separate denied and paid lines into separate encounters. Instead, for Health Plan Denied lines the Health Plan Paid Amount would be reported as zero and the CAS segment, which would report the non-covered charge, would use CARC 96 (Non-covered charge(s) or CARC 16).
Pharmacy	[Placeholder for future guidance]

NOTE: There is a difference between rejected and denied encounters. Health Plans shall not submit encounter data for claims the health plans rejected due to data quality issues. The plans will submit denied encounters.

NOTE: Encounters submitted as Health Plan Administrative Denied go through a limited set of edits.

Questions regarding which edits are set to pend or deny, MQD Encounters can provide an ad-hoc list.

7.2.2. Sub-Capitated

If a plan pays a provider in some method other than fee for service, such as capitation, and that provider sends an encounter to the plan, this is a sub-capitation arrangement and per guidance in QI-2203 plans should **submit these encounters in the paid encounter file** and use the following:

- CN101 CONTRACT INFORMATION should be '05' (Capitated)
- HP Allowed Amount should be set to a non-zero value
- HP Paid Amount would be set to zero

7.2.3. Coordination of Benefits

Two scenarios would result in a zero-pay encounter for coordination of benefits:

- Health Plan A receives a claim for a member but Medicare paid for all services on the claim; Health Plan A assesses no financial liability.
- Health Plan A receives a claim for a member but Health Plan B, also a Medicaid MCO, paid for all services on the claim; Health Plan A assesses no financial liability.
- Health Plan A receives a claim for a member but Health Plan C, a non-Medicaid plan with third party liability for the member pays for all services on the claim; Health Plan A assess no financial liability.

Plans should **submit these encounters in the .deny file**.

7.3. Frequently Asked Questions

This section provides the answers to frequently asked encounter data questions arranged by topic. Questions are listed in tables and grouped into categories. Each question has a Date and a Status. Date represents the last time this question was updated (as it may not have changed since previous versions). Status has one of the following values:

NEW – this version of the document is the first version of the FAQ to include this question

UPDATED – this question is documented in previous versions of the FAQ, but the answer is different in this version than it was in the last version of the FAQ

UNCHANGED - this question is documented in previous versions of the FAQ, and the answer has not changed since the last version of the FAQ