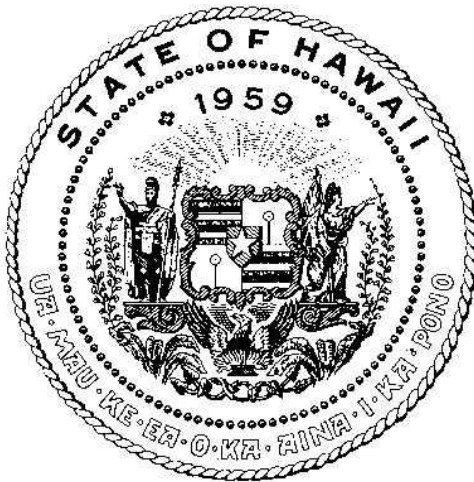# Hawaii PMMIS
Hawaii Prepaid Medical Management Information System

Health Plan Manual

Encounters

Version 2.4
July 2016

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1 Preface

1.1 Overview

The Health Plan Encounter Manual 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.

1.2 Encounter Data Processing

Encounter data reporting for medical services provided to eligible members are submitted electronically by health plans to HPMMIS using the HIPAA 837 file format. These encounters are first edited by our Validator utilizing the HIPAA rules. 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. Encounters that are accepted (pass validation) will continue into our mainframe staging database and be placed in a Wait status for the next encounter cycle.

The encounters that are rejected (do not pass validation) will be reported in either the 999 acknowledgement file (for HIPAA level 1 or 2 errors) or 824 acknowledgement file (for HIPAA level 3-7 errors) and will not continue into our mainframe staging database. 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.

If assistance is needed from the 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)

If there are no rejected encounters, a 999 acknowledgement file will still be generated to report that the file was accepted, along with the 277CA acknowledgement file showing all the accepted encounters.

The NCPDP (pharmacy) encounters will bypass the Validator and 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.

Once an 837 or NCPDP file is successfully loaded into our mainframe staging database, it will remain there until the next encounter cycle is run.

1.3   Conventions Used in this Manual

Unless otherwise stated, the following terms are used in this manual as defined below.

DHS	Department of Human Services
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.
SFTP	Secure File Transfer Protocol (also known as SFTS – Secure File Transfer Server or EFT – Electronic File Transfer)
TPL	Third Party Liability
VPN	Virtual Private Network

2 Encounter Interface

2.1   Encounter Data

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 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.

2.1.1 Encounter Data Reporting

A health plan can submit its encounter information electronically to the MQD on a daily basis, however all encounter files will be processed bi-monthly in HPMMIS on the 1st and 3rd Wednesday of each month. All encounter files must be submitted no later than 5:00 p.m. HST on the Tuesday prior to a processing Wednesday. The encounter information must be submitted via the SFTP process described in section 3.6 Appendix 5A – Med-QUEST/Health Plans File Transfers.

2.1.2 Encounter Definitions

2.1.2.1 Encounter

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.

Only adjudicated encounters should be submitted as part of the bi-monthly encounter data submittal. An adjudicated encounter has been fully edited and verified by the health plan to contain complete and accurate provider data, as defined by the encounter data specifications. Encounter records that have been partially edited or are pending correction or verification should not be submitted as part of the monthly encounter data submission. Denied encounters (claims that were denied by the health plan) should also be reported to Med-QUEST.

Encounters include, but are not limited to, the following items.
   <u>Medical Services</u>
- Inpatient hospital services
- Outpatient hospital services
- Physician and other practitioner services
- Pharmaceutical services
- Preventive care
- Diagnostic services
- Durable medical equipment items
- Home health services

- Transportation services
- Behavioral health services

Behavioral Services
- Inpatient hospital services
- Outpatient hospital services
- Crisis intervention services
- Bio-psycho-social rehabilitation
- Pre-vocational services
- Social/recreational services
- Behavioral health treatment services
- Pharmaceutical services
- Diagnostic laboratory procedures performed
- Transportation services
- Case management visits/contacts

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 downcoded for settlement purposes

2.2   Encounter Record Submission Requirements

Sixty percent of the encounter data should be received by MQD no later than 120 days from the date in which the service was rendered. Health Plans shall have the goal of submitting 100% and shall submit no less than ninety-nine percent (99%) of encounter data within fifteen months from the date of service.

All encounters are expected to be received accurately and in the proper format. Resubmitted encounters (Replacements for 837) and adjustments (for NCPDP) will not be subject to the 120 day submission requirement. In addition, TPL related encounters will not be subject to the 120 day submission deadline.

Penalties for tardy encounter submissions are described in the Request for Proposal (RFP) which served as the basis of the contract between the health plan and the Med-QUEST Division.

The following sections present proper data submission requirements.

2.2.1 Monthly Processing Cycle

Encounter processing occurs during the 1st and 3rd Wednesdays of the month. In order for encounters to be included in the cycle, all encounter submissions 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.

2.2.2 Media for Encounter Submissions

DHS requires health plans to submit encounter data electronically using the SFTP standard over a secure Internet connection. Refer to section 3.6 Appendix 5A – Med-QUEST/Health Plans File Transfers for information on the FTP process. The use of any other method is not acceptable.

Specific instructions for the 837P and 837I encounter data validation are specified in the State of Hawaii Standard Companion Guide Transaction Information for Encounter Reporting (Encounter Companion Guide).

Specific instructions for the NCPDP pharmacy encounter data validation is specified in the State of Hawaii NCPDP Post Adjudicated History (PAH) 2.2 Companion Guide (NCPDP Companion Guide).

2.2.3 Full Edit/Audit Processing

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. 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.

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. Pended encounters will be reported to the health plans via the .241 Encounter Input Detail Report, for correction and resubmission. The record layout for the .241 file is located in Appendix 3a.

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

2.2.4 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.

2.2.4.1   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)

2.2.4.2 UB92 Specific

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

2.2.4.3   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

2.3   Preparing Data for Submission

When reporting encounter data to MQD, a health plan must apply the following guidelines to categorize encounter data.

2.3.1 Institutional

The inpatient encounter should be used to report facility services such as inpatient hospital and institutional services. A maximum of 999 detail lines can be submitted for each encounter of this record type. Do not use this record type for inpatient physician visits or other professional services. Services provided by professional and technical medical providers, hospital-affiliated clinic providers, or persons normally reporting services by an HCFA-1500 claim form are to be reported in the 837 Professional encounter file. Inpatient services that are usually reported on UB-92 claim forms or other institutional claim forms are to be reported in the 837 Institutional encounter file.

2.3.1.1   Interim Inpatient Stays

Health plans are requested not to 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.

2.3.1.2   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).

2.3.2 Reporting Outpatient Encounters

The 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. Also to be reported on this record type is ancillary services for long-term care, sub-acute and waitlist levels of care. Outpatient facility services using this record type have been billed on UB-92 claim forms. A maximum of 999 detail lines can be submitted for each encounter of this record type. Services provided by professional and technical medical providers, hospital-affiliated clinic providers, or persons normally reporting services by an HCFA-1500 claim form are to be reported in the 837 Professional encounter file.

2.3.3 Reporting Pharmacy Encounters

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.

2.3.4 Reporting Professional Encounters

The professional encounter file should be used to report professional and other medical, dental, and behavioral services such as:
- 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 services

Services using this record type are typically associated with HCFA 1500 claim forms or transportation claim forms. Translation and taxi services are also reported on the 837 professional file. A maximum of 999 detail lines can be submitted for each encounter.

2.3.5 Reporting Mixed Paid/Denied Encounter Lines

When an encounter contains both paid and denied lines, they must be reported in a different manner. 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.

For Institutional encounters, the lines do not need to be separated. Instead, 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)).

2.4   Penalties

The following sections present possible sanctions for late, inaccurate, or incomplete data.

In accordance with the QUEST health plan contracts, the State may impose financial penalties or sanctions on the plans for inaccurate, incomplete, and late submissions of required data, information, and reports. The State may impose the specified sanctions to emphasize the importance and need for the data. Any financial sanctions imposed on the health plan shall be deducted from the subsequent month's payment to the plan. The amount of the total sanction for the month shall not exceed ten percent of the monthly capitation payment.

2.4.1 Submitting Timely Data

Timeliness involves the period of time between the date of service and the provision of the encounter data to DHS and the period of time between the deadline for submission of the data and the time the data is provided. Each QUEST Integration (QI) Plan is required to report:

1)   Sixty percent (60%) of the encounter data no more than one-hundred twenty (120) days from the date that services were rendered.
2)   No less than ninety-nine percent (99%) of encounter data within fifteen (15) months from the date of services, with the goal of submitting one-hundred percent (100%) of encounter data within fifteen (15) months from the date of services.

Each health plan ID will be measured individually. The State will conduct a retrospective review of the plan's 15 months of encounter reporting and will determine whether the plan has met the requirements for timeliness of reporting.

2.4.2 Submitting Accurate Data

Data and reports shall be mathematically correct and present accurate information.

The data and information provided to DHS shall be accurate. An accurate encounter is one that reports to DHS a complete and accurate description of the service provided.

2.4.3 Submitting Complete Data

All requested data and information shall be fully disclosed, with no material omissions. Encounter data is not complete if the data has missing or incomplete field information.

The health plan will be notified within 5-9 business days from the receipt date of the initial encounter submission of all encounters that have failed the accuracy and completeness edits. The health plan shall be granted a 30-day error resolution period from the date of notification. If at the end of the 30-day error resolution period, fifteen percent of the initial encounter submission continues to fail the accuracy and completeness edits, a penalty amounting to ten percent of the monthly (initial month's submission) capitation shall be assessed.

The health plan may file a written challenge to the sanctions with DHS not more than 30 days after the health plan receives written notice of the sanction. Challenges will be considered and decisions made by DHS no more than 60 days after the challenge is submitted.

Sanctions are not refundable unless challenged and decided in the favor of the health plan. The health plan shall continue reporting encounter data beyond the term of the contract as processing and reporting of the data is likely to continue due to lags in time in filing source documents by subcontractors and providers.

3 Appendices

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

3.1   Appendix 3A – Encounter Error Report

3.1.1 File Header Record Format
(Encounter Error Report 241)

Item Number	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

3.1.2 QUEST Encounter Input Error Detail Report (EN000241)

#	Data Name	Size	Type	Actual Position From	To	Remarks
1	Health Plan ID	6	AN	1	6	QUEST assigned health plan identifier
2	CRN	15	AN	7	21	Claim Reference Number
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

3.1.3 File Trailer Record Format
(Encounter Error Report 241)

Item Number	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 records)

3.2   Encounter Reporting

3.2.1 Duplicate CRN by Error Code Report (EC97R179)

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                                      13:20
                                                        (ENCOUNTERS)
0TAPE SUPPLIER ID: 99                                                  2ND LINE: IN-PROCESS DATA / 3RD LINE: HISTORICAL DATA
  HEALTH PLAN ID: HP ID                                                ****************************************************
0ERROR CODE AND MESSAGE
  --------------------------------------------------------------------
           CRN           HP CLAIM NUMBER            PATIENT ACCOUNT NO   HP ID  BEGIN DATE  END DATE  F PROVIDER     HAWI ID
      --------------  -------------------------  --------------------  ------ ---------- ---------- - ---------- ---------
 Z720   EXACT DUPLICATE FOUND
        999999999999001 12345678                       12345678        HP ID  02/13/2012 02/13/2012 A 1234567890 000123456
        888888888888002 12345678                       12345678               02/13/2012 02/13/2012 A 1234567890 000123456
- ************* END OF REPORT *************
```

3.2.2 QUEST Hawaii Cycle Encounter Report (ECHAR947)

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.

```
REPORT ID: ECHAR947                    HAWAII CYCLE ENCOUNTER REPORT                        PAGE:    1
PROGRAM #: ECHAL947                                                                         RUN:02/07/2003
                                             AS OF 02/07/2003                                    18:06
    HEALTH PLAN ID: ANY HEALTH PLAN    ANYHEALTHPLAN - MEDICAL
                                       ADJUDICATED           PENDED            HP DENIED &       HP VOIDED &       TOTAL ENCOUNTERS
                                       ENCOUNTERS          ENCOUNTERS          ADJUDICATED       ADJUDICATED         PROCESSED
                                      ------------------  ------------------  ------------------  ------------------  ------------------
   RUN DATE    FORM TYPE                #        %          #        %          #        %          #        %          #        %
   ----------  ---------              ------------------  ------------------  ------------------  ------------------  ------------------
   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
```

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.
Total Encounters Processed	Total of the Adjudicated, Pended, HP Denied & Adjudicated and HP Voided & Adjudicated encounters.
**CM Total	Cumulative total of encounters processed over a specified pe

3.6 Appendix 5A – Med-QUEST/Health Plans File Transfers

3.6.1 Overview

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.

3.6.2 Availability

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.

3.6.3 Logon

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 for 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.

3.6.4 Health Plan Filenames

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:

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

3.6.5 Encounter 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, needs to 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.
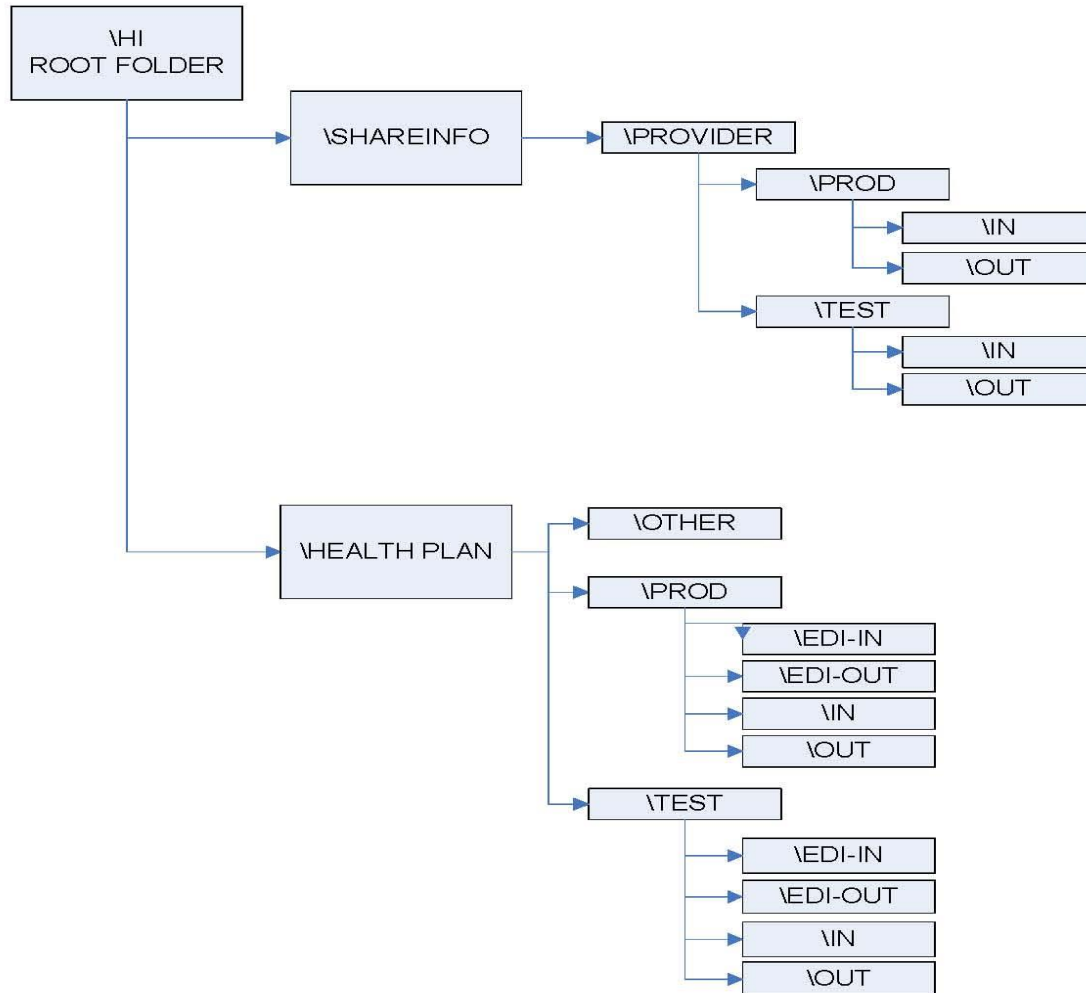
Filenames for the 241, 947 and 179 encounter files will continue to be 10.3 where the first two characters identify the health plan; characters 3-10 is the date of the cycle run. The extensions to these files are listed in a separate column below.

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

3.6.6 Directory Structure

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

HI SFTP (Secure FTP) Directory Structure
https://sftp.statemedicaid.us/HI/

```
\HI
ROOT FOLDER
    ├── \SHAREINFO ──── \PROVIDER
    │                       ├── \PROD
    │                       │       ├── \IN
    │                       │       └── \OUT
    │                       └── \TEST
    │                               ├── \IN
    │                               └── \OUT
    └── \HEALTH PLAN
            ├── \OTHER
            ├── \PROD
            │       ├── \EDI-IN
            │       ├── \EDI-OUT
            │       ├── \IN
            │       └── \OUT
            └── \TEST
                    ├── \EDI-IN
                    ├── \EDI-OUT
                    ├── \IN
                    └── \OUT
```

Last mod: 05/07/2012

3.6.7 Prod Folder

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.

3.6.8 Test Folder

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 every Thursday evening. Please submit your test files by 4:30 pm HST on Thursday at the latest. 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.

3.6.9 Other Folder

The OTHER folder will be used to transmit miscellaneous files or reports between MQD and health plans.

3.6.10   Share Info Folder

Files which do not contain HIPAA data and can be shared with all health plans will be placed under this folder.

3.7   Health Plan IDs

Plan Code	Description (ABD = Aged, Blind, Disabled)
ALOHAC	AlohaCare – Non-ABD Clients
HMSAAA	HMSA – Non-ABD Clients
KAISER	Kaiser – Non-ABD Clients
OHANAA	Ohana (Wellcare) – Non-ABD Clients
UNITED	UnitedHealthcare – Non-ABD Clients
OHANBH	Ohana (Wellcare) – Behavioral Health
XALOHA	AlohaCare – ABD Clients
XHMSAA	HMSA – ABD Clients
XKAISR	Kaiser – ABD Clients
XOHANA	Ohana (Wellcare) – ABD Clients
XUNITD	UnitedHealthcare – ABD Clients

3.8   Health Plan TSN (Tape Supplier Number)

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

4 Contacts

4.1   Systems Office

System	Primary
All Systems	MQD Help Desk 808-692-7953
Encounter	Wileen Ortega 808-692-7990
Provider	Wileen Ortega 808-692-7990
834 Rosters, Recipient (Health Plan members), DMO website, SFTP password reset	Haidee Shaw 808-692-7963

To report problems, please send an email to mqdhelpdesk@medicaid.dhs.state.hi.us.

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

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).

5 Addendums to Health Plan Manual – Encounter

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