Hawaii PMMIS

Hawaii Prepaid Medical Management Information System

HPMMIS Technical Guide

Enrollment

Version 4.9
June 2008

Change Summary

#	Location	Previously Stated	Revision
1	p.98, Appendix B.4 TPL Codes	-	Added TPL Code DM DM Demo Project Pay Drug Co-Pay Only - -
2	p.108, Appendix B.8 Rate Code Summary	-	Added EF18 QUEST ACE FEMALE 65+ 01/01/08 99/99/99 EM18 QUEST ACE MALE 65+ 01/01/08 99/99/99
3	p.111, Appendix B.8 Rate Code Summary	-	Added NF18 QUEST NET FEMALE 65+ 04/01/96 99/99/99 NM18 QUEST NET MALE 65+ 04/01/96 99/99/99
4	p.117, Appendix B.9 maintenance Type Codes and Action Codes	-	Added Action Code AG 024 AG Age Termination Termination of Benefits

Table of Contents

1 Preface 6
1.1 Overview 6
1.2 Eligibility, Enrollment and Payment to Plan 6
1.3 Document Purpose 7
1.3.1 HIPAA Overview 7
1.3.2 Document Objective 8
1.3.3 Intended Users 8
1.3.4 Relationship to HIPAA Implementation Guides 8
1.3.5 Disclaimer 9
1.3.6 Conventions Used in this Manual 9
1.4 Contents of this Document 10
2 834 Enrollment and 820 Capitation Transactions 11
2.1 Electronic Membership Rosters 11
2.2 Transaction Overview 13
2.2.1 Enrollment and Capitation Transactions 13
2.2.2 Processes Replaced or Impacted 14
2.2.3 Other Related Information 14
2.3 834 Enrollment Transaction 15
2.3.1 Purpose 15
2.3.2 Standard Implementation Guide 15
2.3.3 Related Transactions 16
2.3.4 Transmission Schedules 16
2.4 Enrollment and Disenrollment 17
2.4.1 Enrollment Dates 17
2.4.2 Disenrollment Dates 17
2.4.3 Enrollment Corrections 18
2.5 820 Capitation Transaction 19
2.5.1 Purpose 19
2.5.2 Standard Implementation Guide 19
2.5.3 Related Transactions 20
2.5.4 Transmission Schedules 20
2.6 Capitation Rates and Payment 21
2.6.1 Enrollment Rate Codes 21
2.6.2 Monthly Capitation Calculations 21

2.6.3 Daily Capitation Calculations 21
2.6.4 Monthly Payment Summary Report 23
2.6.5 Payment From and Payment Through Dates 23

3 Technical Infrastructure and Procedures 24
3.1 Med-QUEST Data Center Communications Requirements 24
3.2 Technical Assistance and Help 24
3.3 File Transfer and Retention 24
3.4 Med-QUEST/Health Plans' File Transfers 25
3.4.1 Overview 25
3.4.2 Virtual Private Network (VPN) 25
3.4.3 Availability 25
3.4.4 Login 25
3.4.5 Filenames 26
3.4.5.1 File Naming Conventions 26
3.4.6 Directory Structure 27
3.4.7 Production Folder 27
3.4.8 Test Folder 27
3.5 Problem Resolution 28

4 Transaction Standards 29
4.1 General Information 29
4.1.1 HIPAA Requirements 29
4.1.2 Size of Transmissions/ Batches 29
4.1.3 Other Standards 31
4.2 Data Interchange Conventions 33
4.2.1 Overview of Data Interchange 33
4.2.2 Outer Envelope Specifications Table 33
4.3 Acknowledgment Procedures 40
4.3.1 Overview of Acknowledgment Processes 40
4.3.2 997 Functional Acknowledgement 40
4.4 Rejected Transmissions and Transactions 44
4.4.1 Overview of Rejection Process 44

5 Transaction Specifications 45
5.1 About Transaction Specifications 45
5.1.1 Purpose 45
5.1.2 Relationship to HIPAA Implementation Guides 45

5.2 834 Enrollment Transaction Specifications 46
5.2.1 Overview 46
5.2.2 Transaction Specifications Table 46
5.3 820 Capitation Transaction Specifications 77
5.3.1 Overview 77
5.3.2 Transaction Specifications Table 78

6 Contacts 90
6.1 Systems Office (SO) Contacts 90
6.2 Membership File Integrity Section (MFIS) Contacts 90

Appendix A: Examples 91
A.1 Enrollment Corrections 91
Example 1: Erroneous Date of Birth 91
Example 2: Erroneous Date of Death 91
Example 3: Foster Care Client Sent Out-of-State 91
A.2 Daily Capitation Calculations 92
Example: New Enrollment into QUEST 92
Example: Recipient Changing from QUEST-Net to QUEST 92
Example: Time Limits on Retroactive Capitation Adjustments 92
A.3 Payment From and Payment Through Dates 93
Example 1: Newborn 93
Example 2: Date of Death 93

Appendix B: Codes and Values 94
B.1 Ethnicity Codes 94
B.2 Primary Language Codes 95
B.3 Relationship Codes 96
B.4 TPL Codes 97
B.5 Type of TPL Coverage Codes 104
B.6 Health Plan IDs 105
B.7 Island Codes 106
B.8 Rate Code Summary 107
B.9 Maintenance Type Codes and Action Codes 114

1 Preface

1.1 Overview

This Health Plan Manual is directed to medical, dental, behavioral health plans and vendors (Trading Partners) that are contracted with the Hawaii Department of Human Services (DHS), Med-QUEST Division (MQD), to further their understanding of the Hawaii Prepaid Medical Management Information System (HPMMIS).

HPMMIS is operated and maintained by the State of Arizona Medicaid agency known as the Arizona Health Care Cost Containment System (AHCCCS) Administration. This manual contains the transaction data and the various processes to be used by Health Plans and Trading Partners to provide information to and receive information from MQD through HPMMIS.

1.2 Eligibility, Enrollment and Payment to Plan

Eligibility for medical assistance (QUEST and Fee-For-Service) is performed in the Hawaii Automated Welfare Information System (HAWI) and transmitted overnight to HPMMIS. The MQD Enrollment Call Center Section enters enrollment information into HPMMIS.

Historically, Med-QUEST has provided member-level enrollment and capitation information on both Daily and Monthly Health Plan Membership Roster Files. HIPAA standards require enrollment and capitation information to be transmitted on separate files composed of standard electronic transactions. To become HIPAA compliant, Med-QUEST has split the information contained in the Daily and Monthly Roster Files by including enrollment-related information in the 834 Enrollment Transaction and capitation payment related information in the 820 Capitation Payment Transaction.

In addition, Med-QUEST has moved information from other enrollment-related files, including the Med-QUEST TPL File, into the 834 Enrollment Transaction. The 820 Capitation Transaction extracts payment data from financial files built from the Hawaii Prepaid Medical Management Information System (HPMMIS). Med-QUEST 820 data is equivalent to the financial data that formerly appeared on Daily, Monthly and Mass Adjustment Rosters.

1.3 Document Purpose

1.3.1 HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans and employers. They also address the security and privacy of health data.

The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange in health care. The intent of the law is that all electronic transactions, for which standards are specified, must be conducted according to the standards.

Covered entities are required to accept HIPAA Transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both Med-QUEST and its health plans are HIPAA covered entities.

1.3.2 Document Objective

This document provides information about the 834 Enrollment (Daily and Monthly Roster) and the 820 Capitation (Monthly Capitation Payment) Transactions that is specific to Med-QUEST and the ways in which Med-QUEST Trading Partners receive information from Med-QUEST.

1.3.3 Intended Users

This document is intended for members of the technical staff of Health Plans and Trading Partners who are responsible for electronic transactions and file exchanges.

1.3.4 Relationship to HIPAA Implementation Guides

The information in this document is intended to supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content and field values can be found in the Implementation Guides. This document describes the technical interface environment with Med-QUEST, including connectivity requirements and protocols and electronic interchange procedures. This document also provides specific information on the fields and values required for transactions sent to or received from Med-QUEST.

The information in this document is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

1.3.5 Disclaimer

This document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between Med-QUEST, Health Plans and Trading Partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes.

Substantial effort has been taken to minimize conflicts or errors; however, Med-QUEST, the Med-QUEST Systems Office, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in this document, please notify the Med-QUEST Systems Office immediately.

1.3.6 Conventions Used in this Manual

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

DHS	Department of Human Services
FTP	File Transfer Protocol
HAWI	Hawaii Automated Welfare Information System
Health plan	Health plans include medical, dental and behavioral health plans contracted with the State of Hawaii to provide services to eligible members.
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.
MFIS	MFIS is the Member File Integrity Section in MQD, which resolves membership roster problems.
TPL	Third Party Liability
Trading Partners	External entities (such as medical, dental and behavioral health plans and other vendors) who exchange electronic files and transactions with Med-QUEST.
VPN	Virtual Private Network

1.4 Contents of this Document

Preface
Section 1 provides general information on the HIPAA and proprietary files and the various processes to be used by external entities and outlines the information to be included in the remainder of the document.

Transaction Overview
Section 2 provides an overview of the 834 and 820 transactions including information on:

- The purpose of the transaction(s)
- The standard Implementation Guide for the transactions
- Replaced and impacted Med-QUEST files and processes
- Transmission schedules

Technical Infrastructure
Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with Med-QUEST via electronic transactions.

Transaction Standards
Section 4 provides information relating to the 834 and 820 transactions including:

- General HIPAA transaction standards
- Data interchange conventions applicable to the transactions
- Procedures for handling rejected transmissions and transactions

Transaction Agreements
Section 5 provides more specific information relating to the 834 and 820 transaction sets including:

- A statement of the purpose of transaction agreements between Med-QUEST and other covered entities
- Detailed Transaction Specifications that show how Med-QUEST populates the data elements in the 834 Enrollment and 820 Capitation Payment Transactions

Contacts
Section 6 provides contact information for Med-QUEST staff within the Systems Office (SO) and Membership File Integrity Section (MFIS).

2 834 Enrollment and 820 Capitation Transactions

2.1 Electronic Membership Rosters

Eligibility for medical assistance (QUEST and fee-for-service) is performed in HAWI. Eligible QUEST clients then contact the Med-QUEST Enrollment Call Center to make their plan selections, which are entered into HPMMIS. If no plan selections are made within the established timeframes, HPMMIS auto-assigns the eligible QUEST clients to medical and dental plans (As of October 1, 2001, Dental services are provided to the clients by the Medicaid Fee-For-Service Program). When a QUEST member loses eligibility, HAWI sends a termination transaction to HPMMIS, which, in turn, generates a disenrollment transaction. HPMMIS generates daily and monthly electronic membership rosters containing new enrollments and disenrollments for the QUEST plans. Even if there are no transactions, daily files are generated for each plan. These files contain no transactions, but have a trailer record. This is to ensure the plans have not missed any files. The plans obtain the rosters via FTP. (Refer to section *3.4 Med-QUEST/Health Plans' File Transfers* on page 25 for more information.)

The daily 834 contains information about new health plan enrollees, identifies changes to current enrollees and provides disenrollment dates.

Health plans are required to load the daily 834 which contain three types of transactions:

Add (Enrollment) Transactions
When an individual is enrolled in a plan, the plan receives an add transaction with an enrollment begin date. The action code identifies, in general, the reason the client is being added to the plan's membership. Blocks of enrollment to correct errors include begin and end dates that span the period of enrollment.

Change Transactions
Demographic changes are identified on the daily 834s as changes and do not affect enrollment or capitation for the current month. Action codes identify the type of information that has been changed. Rate code changes, which result in capitation changes, are always sent as separate change transactions with action code "RC" and are effective from the first of the next month. Changes in programs and categories are sent as a termination and an add transaction.

Island moves are an exception, where it is not considered as a 'change'. A disenrollment transaction is sent to the old plan and an add transaction is sent to the plan when the client is enrolled on the new island. The Island Code on the address change record represents the original island.

Disenrollment Transactions

When a client is disenrolled from a plan, the plan receives a disenrollment transaction with an enrollment end date. The action code identifies, in general, the reason the client is being disenrolled from the plan's membership. The end date of the enrollment is the last day of enrollment with the plan. Blocks of disenrollment include begin and end dates that span the period of disenrollment.

For additional details, a complete list of action codes is included in *Appendix B.9 Maintenance Type Codes and Action Codes*.

Health plans MUST process each day's transactions in the proper sequence. Processing transactions out of order, or failing to process a transaction, will cause the health plan to have incorrect enrollment information.

When an enrollment error is identified and corrected, HPMMIS sends the corrected enrollment to the health plan, eliminating the need for manual enrollment notification.

2.2 Transaction Overview

2.2.1 Enrollment and Capitation Transactions

834 Enrollment Transaction

The 834 Enrollment Transaction is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy (Med-QUEST) to a health care payer (a Med-QUEST health plan). Enrollment in a particular Med-QUEST health plan differs from more general eligibility for Med-QUEST benefits. Under HIPAA, eligibility information is communicated by the 270/271 Eligibility Verification Transaction Set and detailed information on recipient enrollment in health plans or equivalent entities by the 834 Transaction.

Monthly 834 Transactions identify all active members of a health plan on a given date and are generated in association with monthly capitation pre-payments. Daily 834 Transactions provide data on both an individual's initial enrollment and any data changes during enrollment. Daily 834 Updates generate Daily capitation payments for new health plan enrollees and positive and negative adjustments for retroactive enrollments, enrollment terminations and changes from one Rate Code to another. All capitation payments and subsequent adjustments to those payments that occur as a result of enrollment activity are reflected on the monthly 820 Capitation Transaction.

The Daily 834 Transaction is unique among HIPAA Transactions in that entities external to Med-QUEST (health plans) use data from it to update their systems. Monthly 834 Transactions are for purposes of audit and enrollment verification and are not intended for use in system updates.

With the implementation of HIPAA, 834 Transactions no longer contain information about TPLs that are not true TPLs. Health Plans should remove such TPL codes from their databases. For a complete listing of these codes, refer to *Appendix B.4: TPL Codes*.

820 Capitation Transaction

Med-QUEST makes capitation payments and generates 820 Transactions on a monthly basis. Monthly capitation pre-payments, payments and adjustments from Daily 834s and payments resulting from ad hoc mass adjustment runs are all processed in the monthly health plan payment cycle. Amounts deducted from or added to capitation payments due to such things as health plan sanctions or negotiated settlements are also reported on 820 transactions.

ACS issues checks when it makes capitation payments on behalf of MQD. Each detailed payment documented on the 820 Transaction has a Voucher Number. The same Voucher Number can be associated with information for multiple members. This association makes it possible for receivers of both 820 and 834 Transactions to audit payments at the member level.

2.2.2 Processes Replaced or Impacted

The primary processes replaced by the 834 Enrollment and 820 Capitation Transactions are the Daily and Monthly Roster File interfaces.

834 Enrollment Transaction

Replaced Files
Daily and Monthly Roster Files (enrollment components)
Daily and Monthly TPL Roster Files

Impacted File
None

820 Capitation Transaction

Replaced Files
Daily and Monthly Roster Files (Capitation Payment components)

Impacted File
Mass Adjustment File

Payment amounts, check numbers and payment dates on monthly 820 Transactions must match corresponding information on the electronic payments or checks that Med-QUEST sends to health plans. Mass Adjustments are also handled on the 820 Capitation Transaction.

2.2.3 Other Related Information

Med-QUEST continues to produce several enrollment-related files in the Agency's proprietary format. These files do not make Med-QUEST recipients health plan members and do not require HIPAA Transaction and Code Set compliance.

2.3 834 Enrollment Transaction

2.3.1 Purpose

The 834 Enrollment Transaction transmits enrollment information from the sponsor of the insurance coverage (Med-QUEST) to a health care payer (a Med-QUEST Health Plan) on a daily and monthly basis. The daily version of this transaction provides data on initial enrollments, enrollment terminations and subsequent changes to member-level enrollment data. The monthly version provides a listing of active members that is the basis for the health plan's monthly capitation pre-payment.

The Daily 834 Enrollment Transaction is used to identify:

- New members for whom the health plan is responsible
- Terminated or deceased members for whom the health plan is no longer responsible
- Demographic changes for each member such as changes in name, address or date of birth
- Other changes for each member such as changes in Rate Code or TPL coverage

The Monthly 834 Enrollment Transaction is used to:

- Reconcile health plan and Med-QUEST member files
- Audit updates to health plan data applied from Daily 834 Transactions during the previous month

Data Elements on both Daily and Monthly 834 Transactions carry Voucher Numbers when they result in capitation payments or adjustments. Corresponding Voucher Numbers also appear on the Individual Premium Remittance Detail segment of the 820 Capitation Payment Transaction and can be used to link enrollments to member level capitation payments.

2.3.2 Standard Implementation Guide

The standard Implementation Guide for the 834 Enrollment Transaction is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for Benefit Enrollment and Maintenance and all approved Addenda.

2.3.3 Related Transactions

As used by Med-QUEST, Transaction Specifications for the 834 Transaction are closely related to Transaction Specifications for the 820 Capitation Transaction. All member level capitation payments and adjustments correspond to monthly prepayments, new enrollments, enrollment changes, or mass adjustments due to retroactive rate changes for individual health plan members.

2.3.4 Transmission Schedules

The 834 Daily Enrollment Transaction file showing new members, disenrolled or deceased members and demographic or other changes to current members is produced daily including holidays and weekends. This file is generally available to the health plan on the Med-QUEST FTP Server based on the following schedule:

Available:	Each morning
Available for:	7 days from the date of processing

The 834 Monthly Enrollment Transaction File containing a prospective roster of all currently active members is produced on the last day of each month and is generally available to the Health Plan on the Med-QUEST FTP Server based on the following schedule:

Available:	The morning of the first day of the month
Available for:	30 days from the date of processing or until the next Monthly 834 is generated.

The single 820 file that Med-QUEST sends to each health plan includes the current month's capitation pre-payments and adjustments accumulated during the previous month.

2.4 Enrollment and Disenrollment

Enrollment and disenrollment transactions are sent on the daily 834s.

2.4.1 Enrollment Dates

The enrollment date is the first day of enrollment in a plan. Members may be enrolled on any day of the month. With the exception of newborns that are retroactively enrolled to their dates of birth, and PACE members who are retroactively enrolled upon admission, individuals are enrolled on the next calendar day after MQD accepts the client's plan selection or the client is auto-assigned.

2.4.2 Disenrollment Dates

The disenrollment date is the last day of enrollment in the plan, which, in most instances is the last day of the month. For example, enrollments ending on the last day of the month have end dates of 1/31/00, 2/29/00, etc. There may also be daily enrollment changes based upon MQD policies. For example, when a client becomes pregnant and moves from QUEST-Net to QUEST, the individual will be disenrolled from QUEST-Net and enrolled into QUEST. The disenrollment from QUEST-Net can become effective any day of the month.

Daily disenrollments (which may occur retroactively) are generally limited to clients changing from:

- QUEST-Net to QUEST
- QUEST-ACE to QUEST
- QUEST to FFS
- QUEST-Net to FFS
- QUEST-ACE to FFS
- QUEST to Foster Care Out-of-State (covered by FFS)
- Island Change

Retroactive disenrollments are currently limited to:

- Death
- Incarceration
- Admission to State Hospital
- Out of State
- Wait List

2.4.3 Enrollment Corrections

There may be retroactive changes (blocks of enrollment and disenrollment) to correct enrollment errors.

See *Appendix A.1 Enrollment Corrections* for related examples of the following scenarios:

- Example 1: Erroneous Date of Birth
- Example 2: Erroneous Date of Death
- Example 3: Foster Care Client Sent Out-of-State

2.5 820 Capitation Transaction

2.5.1 Purpose

The 820 Capitation Transaction is a monthly file that provides each Med-QUEST health plan with an electronic remittance advice for its capitation payments. Med-QUEST makes all capitation payments on a monthly basis with an electronic payment or check to each health plan. The Monthly 820 can accumulate and report capitation payments generated during the prior month by Daily 834s, Monthly 834s and Mass Adjustment runs. Settlements, financial sanctions and other payments to and recoupments from health plans that are not member specific can also be included on the 820.

The Med-QUEST Fiscal Agent, Affiliated Computer Services (ACS) produces checks to the Health Plans through the Financial System. ACS specifies the Check Numbers for each monthly payment. Check Numbers for the 820 are entered manually from ACS payment data.

The 820 Transaction is used to:

- Show monthly capitation pre-payments for each health plan member
- Show pro-rated payments for each health plan member who joined during the previous month
- Show positive or negative adjustments that reflect changes to previous capitation payments
- Show positive or negative payment adjustments based on retroactive capitation rate changes by Med-QUEST, usually done through a mass adjustment
- Show Med-QUEST payments and other adjustments that are not member specific.

2.5.2 Standard Implementation Guide

- The standard Implementation Guide for the 820 Transaction is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for the Payroll Deducted and Other Group Payments for Insurance Products Transactions and all approved Addenda.

2.5.3 Related Transactions

As used by Med-QUEST, Transaction Specifications for the 834 Transaction are closely related to Transaction Specifications for the 820 Capitation Transaction. All member level capitation payments and adjustments correspond to monthly prepayments, new enrollments, enrollment changes, or mass adjustments due to retroactive rate changes for individual health plan members.

2.5.4 Transmission Schedules

The 820 Capitation Transaction File is initiated by the Med-QUEST Finance Office and is available the next day to the health plans on the Med-QUEST FTP server.

2.6 Capitation Rates and Payment

The specific capitation rate that a plan is paid for a particular member is determined by a combination of the rate and island codes. The rate and island codes are data values that appear on the Member Level Detail on the 834.

2.6.1 Enrollment Rate Codes

Rate codes reflect the risk adjustment groups for medical plans and adult/child distinction for dental plans. The rate code also identifies which clients have Medicare coverage for SMI behavioral health. The eligibility category (TANF, Foster Care, GA, QUEST, QUEST-Net, S-CHIP and Immigrant Children), gender and age are reflected in the rate codes when applicable. QUEST and QUEST-Net members are distinguished by different rate codes. For example, the rate for a newborn TANF male is a specific rate code. When a newborn is initially enrolled, this rate code is systematically associated with the enrollment. Assuming continued eligibility and enrollment of the newborn, HPMMIS calculates monthly capitation payment using this rate code and the island of residence through the end of the month of the newborn's first birthday. Refer to *Appendix B.8 Rate Code Summary*, for a complete list of enrollment rate codes.

2.6.2 Monthly Capitation Calculations

A prospective monthly capitation payment amount is calculated on the last processing day of the month for each eligible person enrolled on the first day of the following month. The monthly capitation is a set amount determined by rate code and island. It is not prorated for the number of days in the month.

2.6.3 Daily Capitation Calculations

The daily 834s identify the transactions which are comprised of capitation amounts associated with daily enrollment and disenrollment transactions. Daily enrollment and disenrollments are prorated based on the number of days in the month.

Daily changes to enrollment and capitation that are prorated on a daily basis include these types of transactions:

Add

- Newly enrolled eligibles and re-enrollments
- Newborn enrollments with enrollment begin dates retroactive to the date of birth
- Blocks of enrollment for enrollment corrections

Disenroll

Daily disenrollments

- QUEST-Net to QUEST
- QUEST-ACE to QUEST
- QUEST to FFS
- QUEST-Net to FFS
- QUEST-ACE to FFS
- QUEST to Foster Care Out-of-State (covered by FFS)
- Island Change

Retroactive disenrollments

- Death
- Incarcerated
- Admission to State Hospital
- Out of State
- Wait List
- Transplant

Blocks of disenrollment for enrollment corrections

The transactions for these changes include the payment from and through dates and the prorated capitation amounts resulting from the enrollment actions. When a retroactive recovery is made for a person covered by the fee-for-service program, the plan may file claims for reimbursement through the fee-for-service program.

See *Appendix* ***Error! Reference source not found. Error! Reference source not found.*** for related examples of the following scenarios:
Example: New Enrollment into QUEST
Example: Disenrollment from QUEST-Net to QUEST
Example: Time Limits on Retroactive Capitation Adjustments

2.6.4 Monthly Payment Summary Report

MQD will place the Monthly Payment Summary Report on the Med-QUEST FTP server. The Monthly Payment Summary Report includes the capitation for the subsequent month and all adjustments to prior months that occurred since the previous monthly payment summary report was generated. The adjustments are summarized for each day and will reconcile to the amount from each daily 834. The monthly capitation for the subsequent month will reconcile to the monthly 834.

2.6.5 Payment From and Payment Through Dates

The Payment From Date and the Payment Through Date on the 820s are for adds and disenrolls only and represent the period of time being paid or recouped for the transaction.

The Payment From Date can be retroactive (newborns or PACE members, or a death). The Payment Through Date will never be greater than the end of the current processing month.

See *Appendix* ***Error! Reference source not found. Error! Reference source not found.*** for related examples of the following scenarios:

Example 1: Newborn
Example 2: Date of Death

3 Technical Infrastructure and Procedures

3.1 Med-QUEST Data Center Communications Requirements

Health Plans and Trading Partners receive 834 and 820 Transactions from Med-QUEST by connecting to the Med-QUEST Central Site Network. They go from the Internet through a Virtual Private Network (VPN) tunnel to the Med-QUEST File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access.

Health Plans and Trading Partners can contact the Med-QUEST Systems Office at 808-692-7953 for more information on establishing connections through the Med-QUEST FTP Server.

3.2 Technical Assistance and Help

For technical assistance with the electronic data interface files (EDI), Trading partners may contact the Med-QUEST/Systems Office at 808-692-7953. All calls result in a Ticket Number Assignment for problem tracking.

3.3 File Transfer and Retention

Daily 834s remain on the FTP server for 7 calendar days before being deleted. The monthly 834 is available until the next monthly 834 is transmitted. Similarly, the 820 is available until the next 820 is transmitted. For detailed information regarding file transfer procedures, refer to section *3.4 Med-QUEST/Health Plans' File Transfers* on page 25.

3.4 Med-QUEST/Health Plans' File Transfers

3.4.1 Overview

The MQD FTP file server is the source of all file transfers between MQD, the Health Plans, and Trading Partners.Specific technical specifications and instructions have been provided directly to each health plan's technical contact. This section contains basic information regarding the MQD FTP file server.

3.4.2 Virtual Private Network (VPN)

The DHS MQD utilizes the Cisco VPN 3015 Concentrator/Client to secure the file transfers to and from the Health Plans, and Trading Partners.The VPN infrastructure consists of hardware at the MQD Kapolei site and client software allowing up to 100 simultaneous sessions. It uses a combination of unique IDs and alphanumeric passwords issued to each Health Plan, and Trading Partner to authenticate users accessing the MQD file server. As a result, the VPN creates a safe and secure connection over the Internet and allows remote access to the FTP file server with the security of an on-site user.

To obtain the client software and login information, Health Plans and Trading Partners should contact the MQD Systems Office Network Coordinator.

3.4.3 Availability

The FTP file server is available 24 hours a day, seven days a week.

3.4.4 Login

The Health Plan or Trading Partner user ID (login name) is the six-character Health Plan ID that has been assigned to each Health Plan or Trading Partner for HPMMIS. A password has been assigned to the Health Plans and Trading Partners, and verbally communicated to the designated technical contact. Additional technical specifications (IP Address, etc) have been provided directly to the Health Plan's or Trading Partner's technical contact.

3.4.5 Filenames

Filenames follow a standard 8.3 format – eight alphanumeric characters for the filename itself, followed by a three character alphanumeric extension. Each Health Plan and Trading Partner has been assigned a two-character plan identifier for the purpose of naming files. The plan identifiers are:

Identifier	Health Plan
AM	Aloha Care Medical
CB	Department of Health, CAMHD
CD	Cyrca Insurance Management (Dental)
EB	Department of Health, Early Intervention Programs
HB	HMSA Behavioral Health
HM	HMSA Medical
KM	Kaiser
MD	Community Care Management Corporation (Medical Transaportation)
MQ	Med-QUEST Division Files (Provider Master Registry)
SM	Summerlin Medical
TP	SHOTT

3.4.5.1 File Naming Conventions

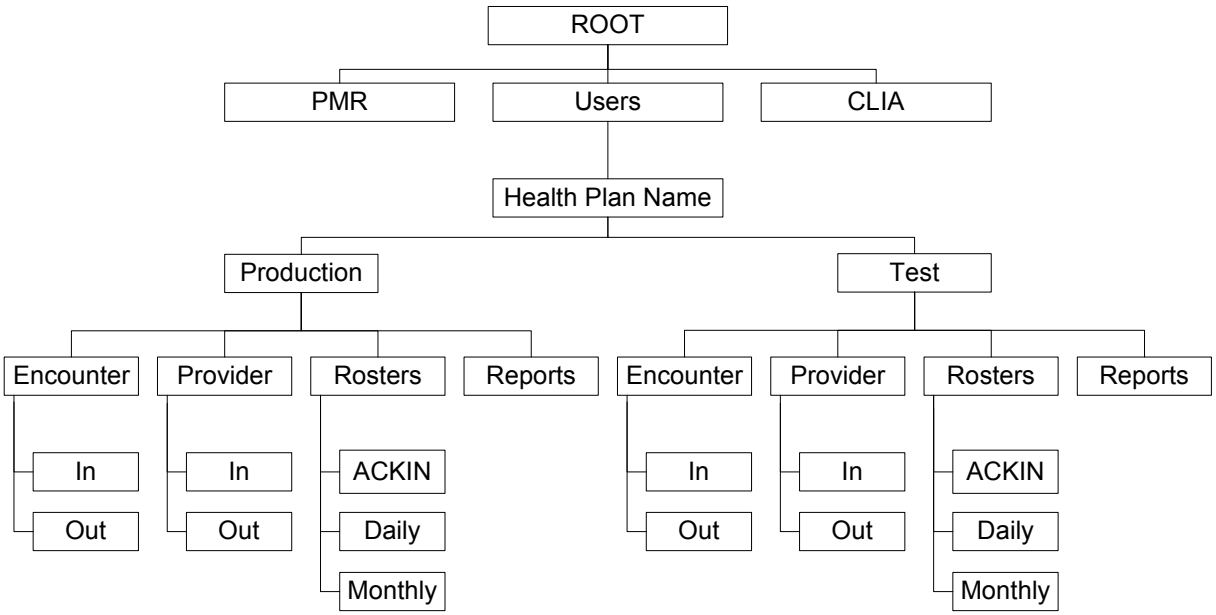
Files are sent and received by Health Plans and Trading Partners using the naming conventions listed in the table below. Filenames use the 8.3 standard; characters 1-2 identify the plans and characters 3-8 identify the date.The extensions to these files are listed in the table below.

Files	Filename	Extension
Acknowledgement Files	**XX**YYMMDD	.997 *or* .824 *or* .TA1
Daily 834	**XX**YYMMDD	.DLR
Monthly 834	**XX**CCYYMM	.MLR
Monthly Payment Summary Report	**XX**CCYYMM	.CAP
Monthly 820	**XX**YYMMDD	.820

3.4.6 Directory Structure

The directory structure for the MQD FTP file server is in the diagram below. The file layouts for encounters, providers and rosters are included in this Health Plan Manual. After the Health Plan or Trading Partner logs onto the MQD FTP file server, there are two primary folders : Production and Test. Both folders contain the same four subfolders : Encounter, Provider, Rosters and Reports.

MQD FTP Directory Structure



3.4.7 Production Folder

Day to day activities with the Health Plans and Trading Partners use the production area of the MQD FTP file server. Data files placed and retrieved from the production folders are processed by HPMMIS and should be processed by the plans to meet their contractual obligations

3.4.8 Test Folder

The test area folders are used for testing changes that the MQD or health plan may need.

3.5 Problem Resolution

Eligibility is determined in HAWI and is transmitted electronically to HPMMIS. HPMMIS maintains and/or determines enrollment and generates daily and monthly 834s and client enrollment notices. HAWI generates eligibility notices. The eligibility caseworker is not involved in resolving enrollment problems.

The Enrollment Call Center answers telephone calls from clients, addresses questions on the enrollment process, explains enrollment policies and enrolls clients into medical, and if appropriate, behavioral health plans. The Member File Integrity Section (MFIS) has been established within the Med-QUEST Division to research, resolve and respond to reported problems with enrollment. Policies, procedures and performance standards have been established for these areas.

When a member contacts the Enrollment Call Center, the enrollment administrator responds with the information in HPMMIS. If the enrollment administrator determines that a problem exists in the interface between HPMMIS and HAWI, then further action is taken to correct the problem, including the potential for referral to MFIS. MFIS resolves discrepancies between eligibility and enrollment and contacts the appropriate eligibility workers to ensure the eligibility is corrected. Following the correction of the eligibility, the MFIS staff corrects the enrollment segments for these clients.

In addition to problem reports from members, plans and others, they review and resolve problem reports generated by HPMMIS. As with HAWI, the client ID is the key to the HPMMIS system. If a client is discovered to have different IDs, or is in more than one case, the health plan should report this immediately to MFIS. An individual active with more than one case will result in multiple transactions (add, change and disenrollment) because of on-going transactions from HAWI with different case ID numbers.

4 Transaction Standards

4.1 General Information

4.1.1 HIPAA Requirements

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. These Addenda have been adopted as final and are incorporated into Med-QUEST requirements.

An overview of requirements specific to each transaction can be found in the 834 and 820 Implementation Guides. Implementation Guides contain information related to:

- Format and content of interchanges and functional groups
- Format and content of the header, detail and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

4.1.2 Size of Transmissions/ Batches

Transmission sizes are limited based on two factors:

- Number of segments/records allowed by HIPAA standards
- Med-QUEST file transfer limitations

HIPAA standards for the maximum file size of each transaction set are specified in the appropriate Implementation Guide or its authorized Addenda. The 834 Implementation Guide recommends a limit of 10,000 INS Member Level Detail Segments in the 2000 Member Level Detail Loop. The 820 Implementation Guide has no recommended limit.

Med-QUEST has no size limitations for postings to its FTP Server.

834 Transactions

Typically, due to constraints imposed upon the 834 Transaction by ASC X12 data structures, no more than 10,000 members can be accommodated on a single file.

The Med-QUEST translator maintains segment counts and automatically limits 834 Transactions (data between ST and SE Segments) to 10,000 INS Segments. Because members sometimes have multiple INS Segments, the 10,000 Segment cut-off is sometimes mid-member. For this reason, successive 834 Transactions (ST through SE Segments) must be processed sequentially within functional groups (GS through GE Segments).

Health plans with thousands of members can expect to sometimes receive multiple 834 Transactions within a functional group, especially for Monthly 834s.

820 Transactions

For 820 Capitation Transactions, there is no Implementation Guide limit to the number of individual members on the same transaction. The number of 2000A Organization Summary and 2000B Individual Remittance Loops on the Monthly 820 Transaction reflects the number of organization or member level capitation payments and adjustments posted for payment and in need of processing.

For large Med-QUEST health plans, Monthly 820 Transactions will sometimes have many thousands of 2000B Individual Remittance Loops. This is because of the Implementation Guide's requirement that the Total Payment Amount on the 820 Transaction match the amount of a check or electronic fund transfer.

4.1.3 Other Standards

820 Capitation Transaction

Balancing Financial Data
There are two types of balancing procedures that both Med-QUEST and its health plans can use to ensure the accuracy of the data in the 820 Capitation Transaction. They are:

- Balancing the total amount of the payment to the capitation receiver (820 Element BPR02) to the sum of all individual and/or organization level capitation payments (Element RMR04). The BPR02 element can only occur once in the entire 820 Capitation Transaction while the member-level RMR04 can occur any number of times.

  When payments or recoupments that are not specific to plan members (e.g., settlements and sanctions) are present, they appear in the 820's 2000A Organization Summary Loop. RMR04 Payment Amounts within the organization level 2000A Loop, as well as the member level Payment Amounts in the 2000B Loop, are included in the transaction level BPR02 total.

- Balancing between the total amount of the payment to the capitation receiver (element BPR02) and the amount of the monthly capitation payment to the health plan (a payment issued by the ACS Financial System) are entered manually by Med-QUEST staff.

  Med-QUEST verifies 820 totals and Financial System payment amounts before it transmits 820 Transactions to health plans. The Agency anticipates that receiving health plans are also making such verifications.

Remittance Tracking
The Trace Number (element TRN02) and the Payer Identification Number (element TRN03) in the 820 Transaction's Reassociation Key (TRN) Segment should be used to reassociate the remittance advice data in the 820 Capitation Transaction with the payment sent separately by the Med-QUEST Fiscal Agent. For Med-QUEST, TRN02 is the Payment Number of the electronic transfer or check written for capitation payment by the ACS Financial System.

Sequence of 2000B Individual Remittance Loops

On the 820 Transactions that it creates for individual member payments, Med-QUEST primarily populates the Individual rather than the Organization Summary version of the 2000 Loop (Loop 2000B rather than 2000A). Each occurrence of 2000B is equivalent to a Daily 834, Monthly 834, or Mass Adjustment Record for a health plan member. Sometimes, a member appears on more than one 2000B Loop because of multiple payments and adjustments.

The content of Daily 834, Monthly 834, or Mass Adjustment run groupings is the same as the content of the proprietary Roster Files that Med-QUEST health plans received in the pre-HIPAA environment. The major difference, aside from changes in transaction format, is that health plans now receive capitation payment data once a month rather than on a daily basis.

4.2 Data Interchange Conventions

4.2.1 Overview of Data Interchange

When transmitting 834 and 820 Transactions to health plans, Med-QUEST follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 834 and 820 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B1 of Implementation Guides.

Transaction Specification tables that show how individual data elements are populated by Med-QUEST on ISA/IEA and GS/GE envelopes appear later in this section. This document assumes that security considerations involving user identifiers, passwords and encryption procedures are handled by the Med-QUEST FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Med-QUEST transmits 834 and 820 Transactions within single ISA/IEA and GS/GE envelopes. 834 Enrollment Transactions, with their limit of 10,000 members per transaction, sometimes have multiple transactions (as defined by ST and SE Segments) within the same GS/GE envelope. 820 Transactions, because they must always correspond to payments, can have any number of payment lines within a transaction and only one transaction per GS/GE envelope.

4.2.2 Outer Envelope Specifications Table

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
The valid values from the Implementation Guide that are used by Med-QUEST.

Definition/Format
Definitions of valid values used by Med-QUEST and additional information about Med-QUEST data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters		Leave field blank – not used by Med-QUEST.
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters		Leave field blank – not used by Med-QUEST.
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters		"MQD" followed by the nine-digit DHS/Med-QUEST Federal Tax ID Number (996001089)
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters		A six-character truncated plan name followed by a nine-digit Federal Tax ID
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC and UCS
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The Interchange Control Number. ISA13 must be identical to the control number in associated Interchange Trailer field IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	0	No Acknowledgement Requested Med-QUEST does not require TA1 Interchange Acknowledgement Segments from its trading partners. If trading partners send them, however, the Med-QUEST translator will receive them and notify Med-QUEST staff of their receipt.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P or T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character	|	A “pipe” (the symbol above the backslash on most keyboards) is the value used by Med-QUEST for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them. Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by Med-QUEST on outgoing transactions: Segment Delimiter - “~’ (tilde – hexadecimal value X”7E”)

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						Element Delimiter - "{" (left rounded bracket – hexadecimal value X"7B") Composite Component Delimiter (ISA16) - "|" (pipe – hexadecimal value X"7C") These values are used because they are not likely to occur within transaction data.
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	**Code identifying a group of application related transaction sets**	BE RA	Benefit Enrollment and Maintenance (834) Payment Order/Remittance Advice (820)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		Med-QUEST repeats the Sender Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		A six-character health plan name specified by Med-QUEST	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMMSS format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		**834 Transaction:** 004010X095A1 **820 Transaction:** 004010X061A1 Med-QUEST uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.	HIPAA Code Set

GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

4.3 Acknowledgment Procedures

4.3.1 Overview of Acknowledgment Processes

Although Med-QUEST does not require receivers of 834 and 820 Transactions to return electronic acknowledgements, it accepts and processes 997 Functional Acknowledgement Transactions. Receivers of 834s and 820s can return 997s as both acknowledgements of valid transactions and notifications of syntactical problems. Extensive syntactical problems are not expected because Med-QUEST applies translator edits to outgoing as well as incoming transactions and corrects any problems revealed by the translator prior to transmission. Discrepancies are possible, however, due to variations in sender and receiver edits.

Med-QUEST Interchange Flows for 834 and 820 Transactions appear later in this section. The flows are similar. Both transactions are built from HPMMIS. They are both processed by the Med-QUEST translator and posted to the Med-QUEST FTP Server to be downloaded by receiving health plans.

4.3.2 997 Functional Acknowledgement

The 997 Functional Acknowledgment Transaction is designed to check each functional group in an interchange for syntax errors and to return the results to the sending trading partner. A “functional group” consists of one or more transactions of the same kind. For example, if a health plan receives Monthly 834 Transactions with 56,000 INS Segments, six 834 Transactions will make up a functional group: five transactions with 10,000 Member Level Detail Loops each and one with the remaining 6,000.

Although each 997 Transaction can accept or reject entire functional groups, its edits can be at the transaction, segment, or data element level. It is sent within its own ISA/IEA and GS/GE envelopes and its segments and elements are of variable lengths. The 997 can be sent as an acknowledgement of receipt for a functional group of transactions or as an indication of syntax errors at the transaction, segment, or data element level.

Characteristics of the 997 Transaction include:

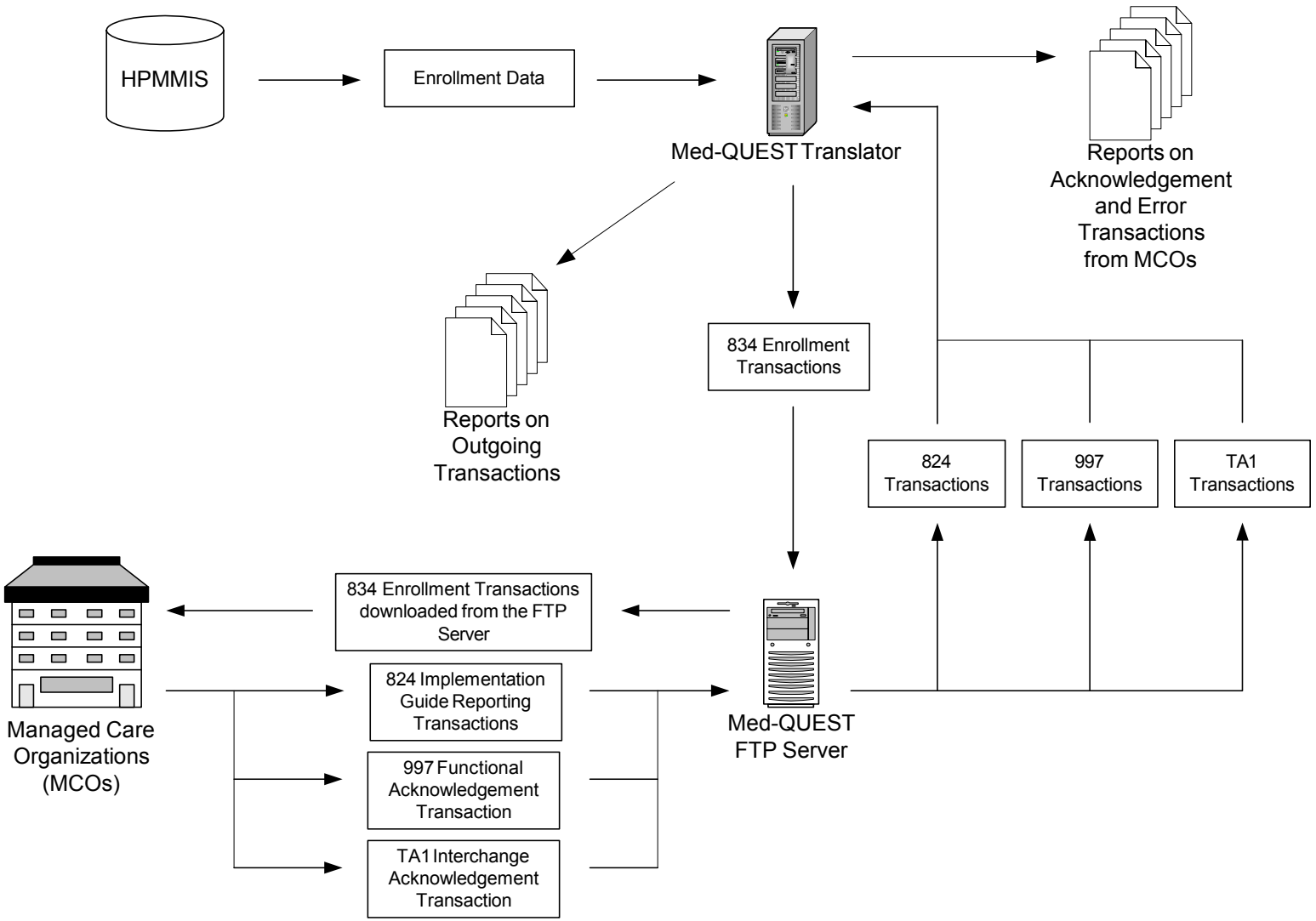
- One 997 Transaction corresponds to one functional group in an interchange.
- 997 Transactions are ASC Transaction Sets and are included in the interchange control structure (envelopes) for transmission.
- Many commercially available translators can automatically reconcile the 997 Transaction back to a previously transmitted functional group. This process allows the sending trading partner to identify any

transactions that have not been acknowledged by the receiving trading partner.

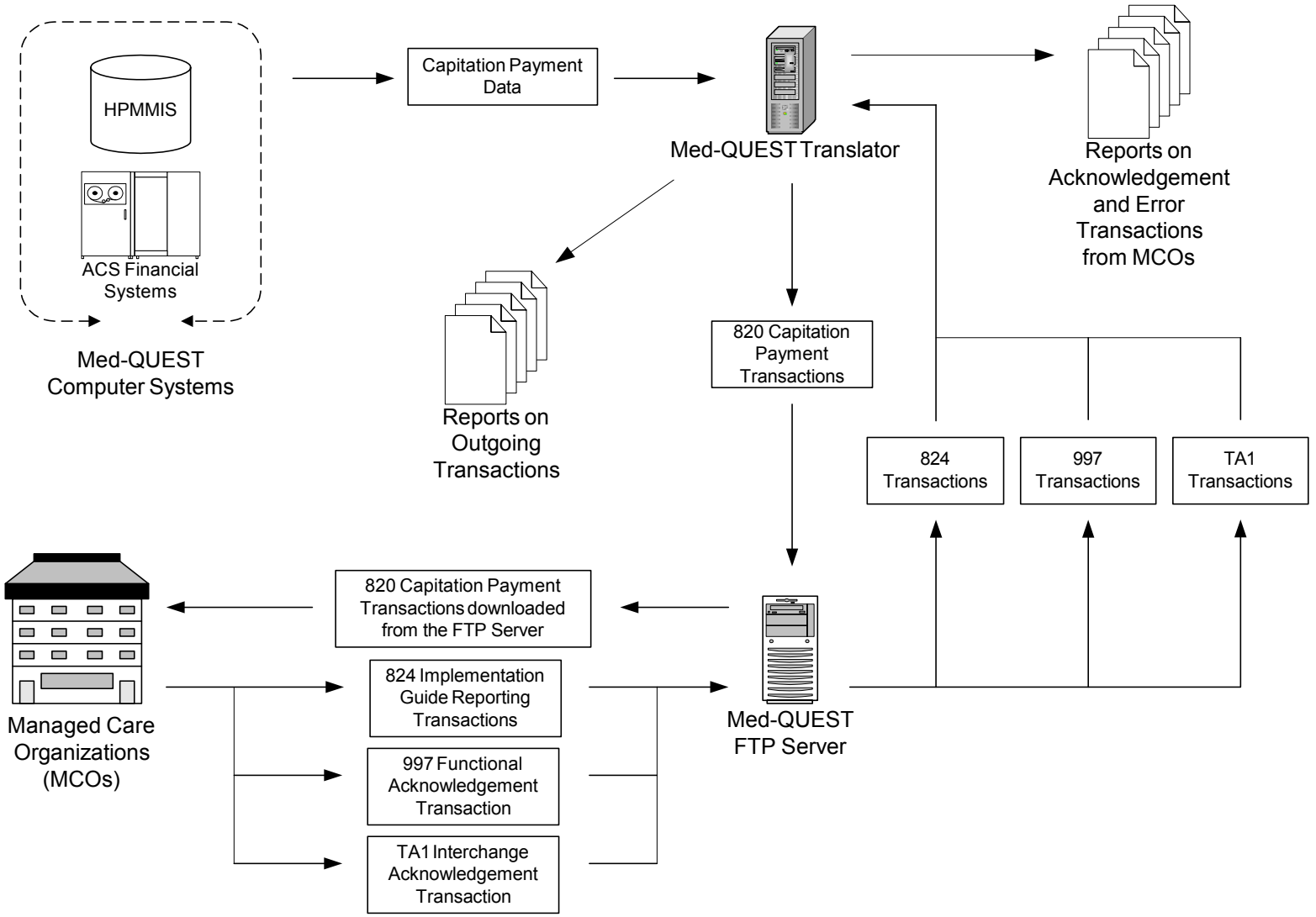
- 997 Transactions should not be used to acknowledge the receipt of other 997 Transactions.

Details on the format and syntax of the 997 Transaction can be found in Appendix B of the Transaction Set's Implementation Guide.

Med-QUEST Interchange Flow - 834 Transaction



Med-QUEST Interchange Flow - 820 Transaction



4.4 Rejected Transmissions and Transactions

4.4.1 Overview of Rejection Process

Med-QUEST expects that its 834 and 820 transmissions will either be accepted and processed by the Health Plans, or, if there are syntactical problems, rejected without further processing. This means that a receiver that rejects any part of a transmission must reject the entire transmission. Data on rejected 834 or 820 transmissions should not be used to update Health Plans' databases.

To support use of the 997 Transaction for 834 and 820 transmissions, Med-QUEST asks the Health Plans to accept or reject the 834 and 820 Transaction at the functional group level. A functional group of one or more transactions represents the scope of the 997 Functional Acknowledgement.

Med-QUEST transmits 834 Transactions within single functional groups, even when multiple transactions (ST through SE Segments) are required. There is no limit to the number of members for whom capitation payment data can be carried on the 820 and no need to have more than one 820 Transaction within a functional group.

5 Transaction Specifications

5.1 About Transaction Specifications

5.1.1 Purpose

The Transaction Specifications document details the code set values that Med-QUEST has established between the Health Plans and specifies the type and format of the information in data elements. In some cases these values are subsets of the data element values listed in Implementation Guides. In others, they are specific to Med-QUEST requirements.

For example, in the Subscriber Number Loop (Loop 2000, Segment REF), element REF02 is defined as an alphanumeric reference identification field that is between 1 and 30 characters long. In the 834 Enrollment Transaction Agreement, REF02 has been defined as the member's HAWI ID. The length and format of the field is based on the characteristics of the HAWI ID rather than on the variable field size defined for the 834.

5.1.2 Relationship to HIPAA Implementation Guides

Transaction agreements are intended to supplement the data in the Implementation Guides for each HIPAA Transaction with specific information pertaining to the trading partners using the transaction.

The information in the Transaction Agreements is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 834 Enrollment Transaction Specifications

5.2.1 Overview

The 834 Enrollment Transaction carries information on new member enrollments, enrollment terminations and changes to information on currently enrolled health plan members. The purpose of these Transaction Specifications is to identify the data elements used in the 834 Enrollment Transaction so that health plans can understand and process the data they receive from Med-QUEST.

5.2.2 Transaction Specifications Table

834 Enrollment Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values listed in the Implementation Guide that are used by Med-QUEST.

Definition/Format
Definitions of valid values used by Med-QUEST and additional information about Med-QUEST data element requirements.

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
Transaction Set Header						
NA	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	834	Transaction Set Code
NA	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set		A Transaction Number assigned by Med-QUEST. It must match the number in SE02 at the end of the transaction
Transaction Set Trailer						
NA	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		Count of all segments between the ST and SE Segments, including the ST and SE Segments
NA	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		This number is the same number that is in data element ST02 Format is numeric from one to ten digits
Beginning Set Header						
NA	BGN	BGN01	Transaction Set Purpose Code	This code identifies the purpose of the transaction set	00	Original Transmission Med-QUEST normally populates this element with “00”. Values on resubmissions are coordinated with trading partners.
NA	BGN	BGN02	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set		Med-QUEST assigns a unique Transaction Number to each 834 Transaction
NA	BGN	BGN03	Transaction Set Creation Date	Identifies the date the submitter created the transaction		CCYYMMDD format
NA	BGN	BGN04	Transaction Set Creation Time	Time file is created for transmission		Time expressed in HHMM format.
NA	BGN	BGN05	Time Zone Code	Code identifying the time zone used in specifying a time	MS	Mountain Standard Time
NA	BGN	BGN06	Transaction St Identifier Code	Code uniquely identifying a Transaction Set		BGN02 value from the original transaction when BGN01 is not “00”
N/A	BGN	BGN08	Action Code	Code indicating type of action	2 4	Change Verify BGN08 “2” transactions contain Adds, Terminations and Changes (equivalent to the Daily Roster). BGN08 “4” transactions contain snapshots of all active Health Plan members (equivalent to the Monthly Roster). Med-QUEST generates both kinds of transactions

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
Transaction Set Policy Number Header						
N/A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	38	Master Policy Number
N/A	REF	REF02	Master Policy Number	The identification of the master policy providing coverage for the entities identified in the transaction		Six-digit Med-QUEST Health Plan ID
Sponsor Name Header						
1000A	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	P5	Plan Sponsor
1000A	N1	N102	Plan Sponsor Name	The name of the entity providing coverage to the subscriber	MED-QUEST	Payer Name
1000A	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Tax ID Number
1000A	N1	N104	Sponsor Identifier	Identification of the party paying for the coverage	996001089	The 834 Transaction's Sponsor Identifier is the Federal Tax ID for Hawaii DHS
Payer Header						
1000B	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	IN	Insurer
1000B	N1	N102	Insurer Name	Name of the insurer providing coverage		Health Plan Name
1000B	N1	N103	Identification Code Qualifier	Codes designating the system/method of code structure used for Identification Code	FI	Federal Tax ID Number
1000B	N1	N104	Insurer Identification Code	Code identifying the insurer providing coverage		Health Plan Federal Tax ID

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
	2000		**Member Level Detail**																
			INS Segment - Member Level Detail																
1	2000	INS	INS01	Insured Indicator	Indicates whether the insured is the subscriber or a dependent	Y	The Member Level Detail 2000 Loop is repeated for every health plan member. In addition, on Daily 834s, the loop occurs (with exceptions) once for each of the up to eight Med-QUEST Action Codes used on each proprietary HPMMIS update record. The major exception is for changes to a member's Name, Date of Birth and/or Gender. Any changes to these elements are instigated by a single Maintenance Reason Code per 2000 Loop. In the HIPAA-compliant system, Maintenance Reason Codes rather than Med-QUEST-specific Action Codes, are intended for use by transaction receivers to determine the kind of updates needed to their databases. All the same, Med-QUEST carries a proprietary HPMMIS Action in the Insured Group or Policy Number REF Segment later in Loop 2000. Yes By definition, all Med-QUEST members are subscribers rather than dependents.	●	●	●	●	●	●	●	●	●	●	●	●
2	2000	INS	INS02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	18	Self	●	●	●	●	●	●	●	●	●	●	●	●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
3	2000	INS	INS03	Maintenance Type Code	Code identifying a specific type of item maintenance		HIPAA Maintenance Type Codes are equivalent to the following proprietary Action Types from the Daily Roster File: <u>Used when BGN08 = "2" (Daily 834)</u> 001 Change - Action Type "C" on proprietary Daily Roster 021 Addition - Action Type "A" on proprietary Daily Roster 024 Termination - Action Type "D" on proprietary Daily Roster <u>Used when BGN08 = "4" (Monthly 834)</u> 030 Audit/Compare - no equivalent Med-QUEST Code The Maintenance Type Code in this loop describes the function of each 2000 Loop.	●	●	●	●	●	●	●	●	●	●	●	●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
4	2000	INS	INS04	Maintenance Reason Code	Code identifying reason for the maintenance change		Daily 834 This critical data element is functionally equivalent to Action Code on the proprietary Daily Rosters. Refer to *Appendix B.8 Maintenance Type Codes and Action Codes* for information on how specific HPMMIS Daily 834 Action Codes are handled. Only a single occurrence of Maintenance Reason Code is allowed per 2000 Loop (rather than the up to eight Action Code occurrences per update record that appeared on proprietary Daily Roster Records). Because of the single occurrence limitation, each of the valid HPMMIS Action Code values for member changes (with two exceptions) generates a separate 2000 Loop and INS Segment. The two exceptions are: • The three HPMMIS Action Code values that relate to name and demographic changes (“NC”, “DB” and “SX”) Any or all of these Action Codes are translated and accommodated on a single 2000 Loop. For the 834 Transaction, demographic changes are defined as changes to a member’s Date of Birth and/or Gender. • The HPMMIS Action Codes that have a financial impact but no impact on member data (“HK” and “SB”) Daily updates with these Action Code values do not appear on the 834 but will appear on the 820 Capitation Transaction. *(cont.)*	●	●	●	●	●	●	●	●	●	●		●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
4 *(cont.)*	2000 *(cont.)*	INS *(cont.)*	INS04 *(cont.)*	Maintenance Reason Code *(cont.)*	Code identifying reason for the maintenance change *(cont.)*	XN	*(continued from above)* Monthly 834 For the Monthly 834, the Maintenance Reason Code to be used is XN. Notification Only To be used in complete enrollment transmissions.	●	●	●	●	●	●	●	●	●	●		●
5	2000	INS	INS05	Benefit Status Code	The type of coverage under which benefits are paid	A	Active	●	●	●	●	●	●	●	●	●	●	●	●
6	2000	INS	INS06	Medicare Plan Code	Code identifying the Medicare Plan		HIPAA Medicare Plan Codes are equivalent to the following proprietary Medicare Codes from the Daily 834: Current Med-QUEST Values	●	●	●	●	●	●	●	●	●	●		●
						A	Medicare Coverage A = Y and Medicare Coverage B = N												
						B	Medicare Coverage A = N and Medicare Coverage B = Y												
						C	Medicare Coverage A = Y and Medicare Coverage B = Y												
						E	Medicare Coverage A = N and Medicare Coverage B = N												
8	2000	INS	INS08	Employment Status Code	A code used to define the employment status of the individual covered by this insurance payer	FT	Full Time.	●	●	●	●	●	●	●	●	●	●	●	●
11	2000	INS	INS11	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Only populated on Daily 834s if Date of Death is present for the member on the HPMMIS Database. Not populated on Monthly 834s. Capitation pre-payments are not generated for deceased members.	●	●	●	●	●	●	●	●	●	●	●	

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
12	2000	INS	INS12	Insured Individual Death Date	Date of death for subscriber or dependent		Date of Death. This field is only populated on the Daily 834 if BGN08 = “2” (Daily Update Transaction). Date expressed in CCYYMMDD format.	●	●	●	●	●	●	●	●	●	●	●	
			REF Segment - Subscriber Number																
18	2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	0F	Subscriber Number	●	●	●	●	●	●	●	●	●	●	●	●
19	2000	REF	REF02	Subscriber Identifier	Insured's or subscriber's unique identification number assigned by a payer		HAWI/Med-QUEST ID for member	●	●	●	●	●	●	●	●	●	●	●	●
			REF Segment - Member Policy Number																
22	2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1L	Group or Policy Number	●	●	●	●	●	●	●	●	●	●	●	●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
23	2000	REF	REF02	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered		On Daily 834s, Med-QUEST strings Rate Code (X[4]) or "RATE" if a Rate Code is not available, Island Code (X[2]), HPMMIS Action Code (X[2]) and, if applicable, Pregnancy Indicator (X[2]). If present, the Pregnancy Indicator has a value of "PG". Changes in a member's Name, DOB and/or Gender can result in HPMMIS Action Code consolidation. When multiple demographic Action Codes appear for an update, a single value is derived for the Action Code sub-field of this element according to the following algorithm: HPMMIS Action Codes — REF02 Action Code Value DB,NC,SX — C1 DB, NC — C2 DB,SX — C3 NC, SX — C4 On Monthly 834s, the member's current Rate Code; "RATE" appears if a Rate Code is not available. On Daily 834s, Med-QUEST will pass "TPL DATA" in this data element when TPL information is present.	●	●	●	●	●	●	●	●	●	●	●	●
			REF Segment - Member Identification Number (1st Segment)																
26	2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	DX	Department/Agency Number If Eligibility worker's Section, Unit, Worker's numbers no blank on 834 Input File, autoplug DX. If Section, Unit, Worker numbers are not present, skip this iteration.	●	●	●	●	●			●	●	●	●	●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types												
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
27	2000	REF	REF02	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber		When “DX” is present, REF02 is the eligibility worker’s Section (X[1]), Unit (X[2]) and Worker (X[2]) Numbers.	●	●	●	●	●			●	●	●	●	●
			REF Segment - Member Identification Number (2nd Segment)																
30	2000	REF	**REF01**	Reference Identification Qualifier	Code qualifying the reference identification	3H	If CASE-ID not Blank on 834 Input File, autoplug '3H'; If CASE-ID Blank skip this iteration	●	●		●	●			●		●	●	●
31	2000	REF	**REF02**	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber		If present, concatenate move CASE-ID and Relationship CD in format CCCCCCCCRR and move to REF02. If Relationship-CD is not present, populate Case ID in the first 10 spaces.	●	●		●	●			●		●	●	●
			REF Segment - Member Identification Number (3rd Segment)																
34	2000	REF	**REF01**	Reference Identification Qualifier	Code qualifying the reference identification	17	If VOUCHER-NUM not Blank on 834 Input File, autoplug '17'; If VOUCHER-NUM Blank skip this iteration	●	●		●	●			●		●	●	●
35	2000	REF	**REF02**	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber			●	●		●	●			●		●	●	●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
			REF Segment - Member Identification Number (4th Segment)																
38	2000	REF	**REF01**	Reference Identification Qualifier	Code qualifying the reference identification	ZZ	If PRI-CLIENT-ID not Blank on 834 Input File, autoplug 'ZZ'; If PRI-CLIENT-ID Blank skip this iteration	●							●		●		●
39	2000	REF	**REF02**	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber			●							●		●		●
			DTP Segment - Member Level Dates																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
46	2000	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	356 357 303	Eligibility Begin Eligibility End Maintenance Effective (HPMMIS Process Date) On Daily 834s, the "Eligibility Begin" or "Eligibility End" Date in this DTP Segment signifies changes in Island or Rate Codes on Daily 834s. Island and/or Rate Code changes trigger capitation payment changes and adjustments on 820 Transactions. On Daily Updates that do <u>not</u> involve Island or Rate Code changes, the date in this field is the Maintenance Effective Date (Qualifier value "303"). Blocks of enrollment to correct errors include begin and end dates that span the period of enrollment. <u>These dates do not show periods of Med-QUEST eligibility.</u> The Implementation Guide's Qualifier values for Eligibility Dates are the closest fit currently available to critical health plan dates. This DTP Segment can occur up to 20 times. On Monthly 834s, this segment carries the Begin Date of the most current Island/Rate Code combination.	●	●	●	●	●	●	●	●	●	●	●	●
47	2000	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8		●	●	●	●	●	●	●	●	●	●	●	●
48	2000	DTP	DTP03	Status Information Effective Date	The date that the status information provided is effective		The date described by the qualifier in DTP01. Date expressed in CCYYMMDD format.	●	●	●	●	●	●	●	●	●	●	●	●
	2100A		**Member Name**																
			NM1 Segment - Member Name																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
52	2100A	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	74 IL	Corrected Insured. This code is used when a change transaction on a Daily 834 Transaction changes a member's name. The Implementation Guide requires this value and population of the 2000B Incorrect Member Name Loop when any of these basic demographic values are changed. Insured/Subscriber. On Daily 834s, this element is used when enrolling a new member or updating a member's Date of Birth or Gender. "IL" is always the value in this required element on Monthly 834s.	●	●	●	●	●	●	●	●	●	●	●	●
53	2100A	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person	●	●	●	●	●	●	●	●	●	●	●	●
54	2100A	NM1	NM103	Subscriber Last Name	The surname of the insured individual or subscriber to the coverage		Med-QUEST member's last name, including suffix if available Med-QUEST carries only 17 characters. If the LAST NAME is longer than 17 characters, Med-QUEST will only populate the first 17 characters	●	●	●	●	●	●	●	●	●	●	●	●
55	2100A	NM1	NM104	Subscriber First Name	The first name of the insured individual or subscriber to the coverage		Med-QUEST member's first name Med-QUEST carries only 10 characters. If the FIRST NAME is longer than 10 characters, Med-QUEST will populate the 10th position with an asterisk.	●	●	●	●	●	●	●	●	●	●	●	●
56	2100A	NM1	NM105	Subscriber Middle Name	The middle name of the subscriber to the indicated coverage or policy		Med-QUEST member's middle initial	●	●	●	●	●	●	●	●	●	●	●	●
			PER Segment - Member Communication Numbers																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
63	2100A	PER	PER01	Contact Function Code	Code identifying the major duty or responsibility of the person or group named	IP	Insured Person. Only populated if a home telephone number for the member is available.	●		●							●		●
65	2100A	PER	PER03	Communication Number Qualifier	Code identifying the type of communication number	HP	Home Phone Number. Only populated if a home telephone number for the member is available.	●		●							●		●
66	2100A	PER	PER04	Communication Number	Complete communications number including country or area code when applicable		Home Telephone Number. Only populated if a home telephone number for the member is available.	●		●							●		●
			N3 Segment - Member Residence Street Address																
72	2100A	N3	N301	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		First line of member's residence street address.	●		●							●		●
73	2100A	N3	N302	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		Second line of member's residence street address, if non-blank.	●		●							●		●
			N4 Segment - Member Residence City, State, ZIP Code																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
74	2100A	N4	N401	Subscriber City Name	The City Name of the insured individual or subscriber to the coverage		Member's residence city.	●		●							●		●
75	2100A	N4	N402	Subscriber State Code	The State Postal Code of the insured individual or subscriber to the coverage		Member's residence state.	●		●							●		●
76	2100A	N4	N403	Subscriber Postal Zone or ZIP Code	The ZIP Code of the insured individual or subscriber to the coverage		Member's residence Zip Code (9 digit when available).	●		●							●		●
78	2100A	N4	N405	Location Qualifier	Code identifying type of location	CY	County/Parish	●		●							●		●
79	2100A	N4	N406	Location Identification Code	Code which identifies a specific location		County (Island) Code For Hawaii, N406 is the recipient's Island Code. Island Code, along with Rate Code in the Insured Group or Policy Number REF02 Element of the Loop 2000 REF Segment, defines Med-QUEST capitation rate categories.	●		●							●		●
			DMG Segment - Member Demographics																
80	2100A	DMG	DMG01	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8		●	●		●			●	●		●		●
81	2100A	DMG	DMG02	Member Birth Date	The date of birth of the member to the indicated coverage or policy		Date of Birth Date expressed in CCYYMMDD format.	●	●		●			●	●		●		●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
82	2100A	DMG	DMG03	Gender Code	A code indicating the gender of the patient or insured	F M	Female Male	●	●		●			●	●		●		●
84	2100A	DMG	DMG05	Race or Ethnicity Code	Code indicating the racial or ethnic background of a person	 7 A A A A A E E H H I J N O P P	HIPAA Race or Ethnicity Codes are equivalent to the following proprietary Medicare Codes from the Daily and Monthly Roster Files: UN (Unknown/Unspecified) CH (Chinese) FI (Filipino) JA (Japanese) KO (Korean) OA (Other Asians) MI (Mixed OT (Other – include HAWI value of “UN”) HI (Hispanic) PR (Puerto Rican) AI (American Indian/Alaskan Native HA (Hawaiian Native) BL (Black not of Hispanic origin) WH (White not of Hispanic origin) OP (Other Pacific Islanders) SA (Samoan) Addenda to the 834 Implementation Guide add several new Race/Ethnicity Code values. Some of these values (including “J” for Native Hawaiian) have been adopted by Med-QUEST.	●							●		●		●
			LUI Segment - Member Language																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
105	2100A	LUI	LUI01	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	LE	ISO 639 Language Codes Med-QUEST uses three-character ISO 639-2 Codes. Some, but not all, of the ISO 639-2 Codes used by Med-QUEST have the same values as NISO Z39.53 Language Codes. Med-QUEST uses the LUI Segment for the primary language spoken in the member's household.	●							●		●		●
106	2100A	LUI	LUI02	Language Code	Code indicating the language spoken by an individual	 CHI ZHO ENG HAW ILO JPN KMH KOR LAO PHI SGN SMO SPA TGL TON UND UND VIE	HIPAA compliant ISO 639-2 Language Codes are equivalent to the following proprietary Medicare Codes from the Daily and Monthly Roster Files: C (Chinese, Cantonese) M (Chinese, Mandarin) E (English) H (Hawaiian) I (Filipino, Ilocano) J (Japanese) B (Cambodian) K (Korean) L (Laotian) F (Filipino, Other) D (Sign Language) N (Samoan) S (Spanish) G (Filipino, Tagalog) T (Tongan) P (South Pacific [other]) O (Other) V (Vietnamese)	●							●		●		●
	2100B		**Incorrect Member Name**																
			NM1 Segment - Incorrect Member Name																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
110	2100B	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	70	Prior Incorrect Insured. According to the 834 Implementation Guide, "This segment only used if a corrected name is sent in loop 2100A or if previously supplied demographics are being changed. If only the demographics are being changed, then the code value of NM101 in Loop 2100A will be IL, and the code value of NM101 in this loop will be 70." "Demographics", in this context, are limited to the fields for which former, incorrect values appear in Loop 2100B. Changes that require population of elements on this loop for Med-QUEST are: • Previous Last Name • Previous First Name • Previous Middle Name/Initial • Previous Date of Birth • Previous Gender Any of the above elements may be populated when there is a change in any of them for an enrolled member. The 2100B Incorrect Member Name Loop does not appear on Monthly 834s.				●			●					
111	2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person				●			●					
112	2100B	NM1	NM103	Prior Incorrect Insured Last Name	The last name previously reported or used for an individual when a corrected name is reported		Prior Incorrect Last Name. Incorrect information that is being changed. Used when NM101 in Loop 2100A is 74. Med-QUEST carries only 17 characters. If the LAST NAME is longer than 17 characters, Med-QUEST will only populate the first 17 characters				●			●					

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
113	2100B	NM1	NM104	Prior Incorrect Insured First Name	The first name previously reported or used for an individual when a corrected name is reported		Prior Incorrect First Name. Incorrect information that is being changed. Used when NM101 in Loop 2100A is 74. Med-QUEST carries only 10 characters. If the FIRST NAME is longer than 10 characters, Med-QUEST will populate the 10th position with an asterisk.				●			●					
114	2100B	NM1	NM105	Prior Incorrect Insured Middle Name	The middle name previously reported or used for an individual when a corrected name is reported		Prior Incorrect Middle Name. Incorrect information that is being changed. Used when NM101 in Loop 2100A is 74.				●			●					
			DMG Segment - Incorrect Member Demographics																
121	2100B	DMG	DMG01	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Used when a member's Date of Birth is being changed.				●			●					
122	2100B	DMG	DMG02	Prior Incorrect Insured Birth Date	The birth date previously reported or used for an individual when corrected data is reported		Prior Incorrect Date of Birth Date expressed in format CCYYMMDD. Used when a member's Date of Birth is being changed.				●			●					
123	2100B	DMG	DMG03	Prior Incorrect Insured Gender Code	The gender previously reported or used for an individual when corrected data is reported		Prior Incorrect Gender Used when a member's Gender is being changed.				●			●					
	2100C		**Member Mailing Address**																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
			NM1 Segment - Member Mailing Address																
130	2100C	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	31	Member's Postal Mailing Address	●		●							●		●
131	2100C	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person	●		●							●		●
			N3 Segment - Member Mail Street Address																
141	2100C	N3	N301	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		First line of member's mailing street address.	●		●							●		●
142	2100C	N3	N302	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		Second line of member's mailing street address, if present.	●		●							●		●
			N4 Segment - Member Mail City, State, ZIP Code																
143	2100C	N4	N401	Subscriber City Name	The City Name of the insured individual or subscriber to the coverage		Member's mailing city.	●		●							●		●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types												
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
144	2100C	N4	N402	Subscriber State Code	The State Postal Code of the insured individual or subscriber to the coverage		Member's mailing state.	●		●							●		●
145	2100C	N4	N403	Subscriber Postal Zone or ZIP Code	The ZIP Code of the insured individual or subscriber to the coverage		Member's mailing ZIP Code (9 digit when available).	●		●							●		●
	2100G		**Responsible Person**																
			NM1 Segment - Responsible Person																
233	2100G	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	QD	Responsible Person The 2100G Loop is for data that identifies "the person responsible for the member." Med-QUEST uses the loop in two ways which may not be relative to each other: • Responsible Person - The primary person in the member's case (always present – can be the member) • Medical Payee Address – The address used to specify where the Medical ID card should be sent.	●		●					●		●		●
234	2100G	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person	●		●					●		●		●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types												
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
235	2100G	NM1	NM103	Responsible Party Last or Organization Name	Last name or organization name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The last name of the primary person in the case. Med-QUEST carries only 17 characters. If the LAST NAME is longer than 17 characters, Med-QUEST will only populate the first 17 characters	●		●					●		●		●
236	2100G	NM1	NM104	Responsible Party First Name	First name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The first name of the primary person in the case. Med-QUEST carries only 12 characters. If the FIRST NAME is longer than 12 characters, Med-QUEST will populate the 12th position with an asterisk.	●		●					●		●		●
237	2100G	NM1	NM105	Responsible Party Middle Name	Middle name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The middle initial of the primary person in the case.	●		●					●		●		●
			N3 Segment - Responsible Person Street Address																	

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
253	2100G	N3	N301	Responsible Party Address Line	Address line of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The first line of the “Medical Payee Address” if it is present	●		●							●		●
254	2100G	N3	N302	Responsible Party Address Line	Address line of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The second line of the “Medical Payee Address” if it is present	●		●							●		●
			N4 Segment - Responsible Person City, State, ZIP Code																
255	2100G	N4	N401	Responsible Party City Name	City name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The city of the “Medical Payee Address” if it is present	●		●							●		●

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
256	2100G	N4	N402	Responsible Party State Code	State or province of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The State Code of the “Medical Payee Address” if it is present	●		●							●		●
257	2100G	N4	N403	Responsible Party Postal Zone or ZIP Code	Postal ZIP code of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The ZIP Code of the “Medical Payee Address” if it is present May be either five or nine digits.	●		●							●		●
	2300		**Health Coverage**																
			HD Segment - Health Coverage																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
272	2300	HD	HD01	Maintenance Type Code	Code identifying a specific type of item maintenance		HIPAA compliant Maintenance Type Codes are equivalent to the following proprietary Action Type Codes from the Daily and Monthly 834s. In the 2300 Loop, the codes refer to a health plan coverage (with up to 99 past or present coverages per member).	●		●	●	●	●	●	●	●	●	●	●
							Used on Daily 834s												
						001	Change – Change in an existing coverage for a health plan member												
						021	Addition – Addition of a new coverage for a new or existing health plan member												
						024	Termination – Ending of a coverage for an existing or terminating health plan member												
							Used on Monthly 834s												
						030	Audit/Compare - No equivalent Med-QUEST Code												
							This loop gives health plans member enrollment information (including enrollments in other health plans) in terms of coverage and benefits. The loop is repeated for each Med-QUEST health plan, in which the member is enrolled.												
							TPL data begins in the 2320 COB Loop within the first 2300 Loop of the first 2000 Loop sent to the receiving health plan. If there are more than five current or past TPL carriers for a member, overflow carriers appear on subsequent 2300 Loops. These subsequent TPL 2300 Loops are “continuation loops” that carry only TPL data, plus elements required by the 834 Implementation Guide or needed for loop identification.												
							(cont.)												

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
272 *(cont.)*	2300 *(cont.)*	HD *(cont.)*	HD01 *(cont.)*	Maintenance Type Code *(cont.)*	Code identifying a specific type of item maintenance *(cont.)*		*(continued from above)* Complete TPL data structured in this manner appears for members with third party coverage in the following situations: • On Monthly 834s • On Daily 834s for newly enrolled members • On Daily 834s when there is any change to a member's TPL coverage	●		●	●	●	●	●	●	●	●	●	●
274	2300	HD	HD03	Insurance Line Code	Code identifying a group of insurance products	HMO AK DCP	HIPAA compliant Insurance Line Codes are equivalent to the following types of Med-QUEST health plans: Health Maintenance Organization [Medical Health Plans] Mental Health [Behavioral Health Entities] Dental Capitation [Capitated Dental Clinics] This is the field that determines the kind of 2300 Loop that follows. On Monthly 834s, an HMO loop is required for the medical health plan. The remaining 2300 Loops appear if applicable to the recipient.	●		●	●	●	●	●	●	●	●	●	●
275	2300	HD	HD04	Plan Coverage Description	A description or number that identifies the plan or coverage		The Health Plan Name (X[25]) appears in this element. On Daily 834 re-enrollments and health plan changes, the Prior Plan Name (X[25]) follows the name of the current plan.	●		●	●	●	●	●	●	●	●	●	●
			DTP Segment - Health Coverage Dates																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
283	2300	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	303 348 349	Maintenance Effective (Daily 834s only) Benefit Begin Used when a member is enrolled in the product specified in the Insurance Line Code. Benefit End Used when a member is disenrolled from the coverage specified in the Insurance Line Code. A DTP Segment for Health Coverage Dates is required for each 2300 Loop. Dates in this segment correspond to Begin and End Dates for enrollment in a health plan. Begin Dates and End Dates require separate DTP Segments if both are present for a coverage. The "303" code appears when coverage data is changed but, in the words of the Implementation Guide, "a member's coverage is not being added or removed." In this situation, element HD01 will have a value of “001” (Change).	●		●	●	●	●	●	●	●	●	●	●
284	2300	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Used when DTP01 above is populated.	●		●	●	●	●	●	●	●	●	●	●
285	2300	DTP	DTP03	Coverage Period	The coverage period associated with this premium payment		The Enrollment Begin Date, the Enrollment End Date, the Process Date (Daily 834s only). Date expressed in format CCYYMMDD.	●		●	●	●	●	●	●	●	●	●	●
			REF Segment - Health Coverage Policy Number																

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
292	2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	17	Client Reporting Category	●		●	●	●	●	●	●	●	●		●
293	2300	REF	REF02	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered		Contract Type (X[01]) and Behavioral Health Reporting Category (X[01]) . Behavioral Health Reporting Category appears only for behavioral health coverages.	●		●	●	●	●	●	●	●	●		●
	2320		**Coordination of Benefits**																
			COB Segment - Coordination of Benefits																
332	2320	COB	COB01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	U	Unknown											●	

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
333	2320	COB	COB02	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered		Five HPMMIS fields are used to populate this element with a maximum length of 14 characters: TPL Code (X[2]) TPL Sequence Number (X[2]) Absent Parent Indicator (X[1]) Last Modification Date (CCYYMMDD) (X[8]) Type of TPL Coverage Code (X[1]) The COB02 sub-fields are positional. Prior to the final field, spaces or zeros are present if data is not available. The final sub-field (Type of TPL Coverage Code) populates only if the TPL Coverage Code is present. If the TPL Coverage Code is not present, the maximum length of this element is 13 characters.											●	
334	2320	COB	COB03	Coordination of Benefits Code	Code identifying whether there is a coordination of benefits	5	Unknown											●	
			REF Segment - Additional Coordination of Benefits Identifiers																
335	2320	REF	**REF01**	Reference Identification Qualifier	Code qualifying the reference identification	6P	Group Number											●	

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
336	2320	REF	**REF02**	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered		TPL Policy Number (X[15])											●	
			N1 Segment - Other Insurance Company Name																
339	2320	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	IN	Insurer											●	
340	2320	N1	N102	Insurer Name	Insurer Name		Descriptive Name of the TPL Carrier											●	
			DTP Segment - Coordination of Benefits Eligibility Dates																
345	2320	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	344	Begin Date for Other Insurance Coverage											●	
346	2320	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Used when DTP01 above is populated.											●	
347	2320	DTP	DTP03	Coordination of Benefits Date	The dates of eligibility for coordination of benefits		Begin Date for Other Insurance Coverage. Date expressed in format CCYYMMDD. Used when DTP01 above is 344.											●	

#	Loop	Segment	Element	Clarifications for use of Elements				834 Action Types											
				Element Name	Element Definition	Valid Values	Definition/Format	Add Enroll	Disenroll	Address Change	DOB/Gender Change	HP Change	Mental Health Change	Name, DOB, Gender	Other Change	Pregnant Change	Rate Code Change	TPL Only	Monthly
			DTP Segment - Coordination of Benefits Eligibility Dates																
348	2320	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	345	End Date for Other Insurance Coverage											●	
349	2320	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in format CCYYMMDD. Used when DTP01 above is populated.											●	
350	2320	DTP	DTP03	Coordination of Benefits Date	The dates of eligibility for coordination of benefits		End Date for Other Insurance Coverage. Used when DTP01 above is 345. Date expressed in format CCYYMMDD.											●	
			SE Segment - Transaction Set Trailer																
507	N/A	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		Count of all segments between the ST and SE Segments, including the ST and SE Segments.	●	●	●	●	●	●	●	●	●	●	●	●
508	N/A	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		This number is the same number that is in data element ST02. Format is numeric from one to ten digits.	●	●	●	●	●	●	●	●	●	●	●	●

5.3 820 Capitation Transaction Specifications

5.3.1 Overview

The purpose of these Transaction Specifications is to identify the data elements used in the 820 Capitation Transaction so that health plans and other entities that receive 820 Transactions from Med-QUEST are able to understand and process transaction data. The monthly 820 Transaction does not include or accompany the actual capitation payments. It serves as a detailed capitation remittance advice that shows capitation payments and adjustments for each member, as well as payments and adjustments that are not member specific. The 820 Transaction represents the financial aspect of the proprietary Daily and Monthly Roster Files.

Affiliated Computer Services (ACS), the Med-QUEST Fiscal Agent implements Agency policy by making monthly capitation payments to health plans and other entities paid on a per member or per recipient basis. For most capitated entities, the monthly 820 reflects the data used to create 834 Enrollment Transactions, both monthly and daily. It also includes member-level adjustments that result from the mass adjustment process (i.e., adjustments that result from retroactive changes to capitation rates). There may be the possibility that entities could receive 820s without 834s. In these situations, the 820 Transactions serve as payment rosters for eligible recipients.

5.3.2 Transaction Specifications Table

820 Capitation Transaction Specifications for individual data elements are shown in the table beginning on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values listed in the Implementation Guide that are used by Med-QUEST.

Definition/Format
Definitions of valid values used by Med-QUEST and additional information about Med-QUEST data element requirements.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
Transaction Set Header						
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	820	Transaction Set Number
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set		A unique Transaction Number assigned by Med-QUEST. The value of this element must be the same as that of the SE02 element at the end of the transaction.
Financial Information						
N/A	BPR	BPR01	Transaction Handling Code	This code designates whether and how the money and remittance information are processed	U	Remittance Information Only
N/A	BPR	BPR02	Total Premium Payment Amount	The total premium payment for this batch or transaction		The total payment amount on the 820 Transaction. This amount is the sum of the amounts in the RMR04 Detail Premium Payment Amount elements in the 2000A and/or 2000B Loops. It must also equal the amount of the health plan payment.
N/A	BPR	BPR03	Credit or Debit Flag Code	Code indicating whether amount is a credit or debit	C	Credit Negative dollar amounts are made with the Credit Flag by assigning a negative value to BPR02.
N/A	BPR	BPR04	Payment Method Code	Code identifying the method for the movement of payment instructions	ACH CHK FWT	Automated Clearing House Check Wire Transfer
N/A	BPR	BPR05	Payment Format Code	Type of format chosen to send payment	CCP	Concentration/Addenda plus Disbursement Used only with “ACH” of “FWT” networks. This element is blank when BPR04 = CHK
N/A	BPR	BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	Code identifying the type of identification number of Depository Financial Institution (DFI)	01	ABA (9-digit Transit Routing Number including check digits) originating the transaction when BPR04 is “ACH” or “FWT”. This element is blank when BPR04 = CHK

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
N/A	BPR	BPR07	Originating Depository Financial Institution (DFI) Identifier	Number identifying the financial institution originating the transaction in an ACH network		ABA number of the financial institution originating the transaction when BPR04 is “ACH” or “FWT”. This element is blank when BPR04 = CHK
N/A	BPR	BPR08	Account Number Qualifier	Code indicating the type of account	DA	When BPR04 is “ACH” or “FWT”. This element is blank when BPR04 = CHK
N/A	BPR	BPR09	Sender Bank Account Number	The sender's bank account number at the Originating Depository Financial Institution		Bank Account Number of the financial institution originating the transaction when BPR04 is “ACH” or “FWT”. This element is blank when BPR04 = CHK
N/A	BPR	BPR10	Originating Company Identifier	A unique identifier designating the company originating the transaction	1996001089	The DHS/Med-QUEST Federal Tax ID Number preceded by the number “1”. For the organization originating the transaction.
N/A	BPR	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	Code identifying the type of identification number of Depository Financial Institution (DFI)	01	ABA (9-digit Transit Routing Number including check digits) of the financial institution receiving the transaction when BPR04 is “ACH” of “FWT”. This element is blank when BPR04 = CHK
N/A	BPR	BPR13	Receiving Depository Financial Institution (DFI) Identifier	Number identifying the financial institution receiving the transaction from an ACH network		ABA number of the financial institution receiving the transaction when BPR04 is “ACH” or “FWT”. This element is blank when BPR04 = CHK
N/A	BPR	BPR14	Account Number Qualifier	Code indicating the type of account	DA	When BPR04 is “ACH” or “FWT”. This element is blank when BPR04 = CHK
N/A	BPR	BPR15	Receiver Bank Account Number	The receiver's bank account number at the Receiving Depository Financial Institution		Bank Account Number of the financial institution receiving the transaction when BPR04 is “ACH” or “FWT”. This element is blank when BPR04 = CHK
N/A	BPR	BPR16	Check Issue or EFT Effective Date	Date the check was issued or the electronic funds transfer (EFT) effective date		Date that the check was issued or that Med-QUEST intends the transaction to be settled

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
Reassociation Key						
N/A	TRN	TRN01	Trace Type Code	Code identifying the type of reassociation which needs to be performed	3	Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.
N/A	TRN	TRN02	Check or EFT Trace Number	Check number or Electronic Funds Transfer (EFT) number that is unique within the sender/receiver relationship		Check Number or Trace Number (for electronic funds transfers)
N/A	TRN	TRN03	Originating Company Identifier	A unique identifier designating the company originating the transaction	1996001089	The DHS/Med-QUEST Federal Tax ID Number preceded by the number “1”. For the organization originating the transaction.
Premium Receivers Identification Key						
N/A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	14	Master Account Number
N/A	REF	REF02	Premium Receiver Reference Identifier	The key or reference number used by the premium receiver to designate to which plan, invoice, or account number the premium payment is to be applied		Med-QUEST Health Plan ID
Coverage Period						
N/A	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	582	Report period This segment has the Start and End Dates associated with the covered period paid by this 820 Transaction. The begin date is the earliest payment date affected and the end date the last day of the pre-payment month.
N/A	DTM	DTM05	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	Range of dates
N/A	DTM	DTM06	Coverage Period	The coverage period associated with this premium payment		Payment From/Payment Thru Dates expressed in format CCYYMMDD – CCYYMMDD.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
Premium Receiver's Name						
1000A	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PE	Payee
1000A	N1	N102	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		Health Plan Name
1000A	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer ID Number
1000A	N1	N104	Receiver Identifier	Number identifying the organization receiving the payment		Health Plan Tax ID Number
Premium Receiver's Address						
1000A	N3	N301	Receiver Address Line	The receiver's address line		Health Plan or Agency Street Address Line 1
Premium Receiver's City, State, Zip						
1000A	N4	N401	Information Receiver City Name	The City Name of the Information Receiver's address		Health Plan or Agency City
1000A	N4	N402	Information Receiver State Code	The State Postal Code of the Information Receiver's address		Health Plan or Agency State
1000A	N4	N403	Information Receiver Postal Zone or ZIP Code	The Zip Code of the Information Receiver's address		Health Plan or Agency Zip Code
Premium Payer's Name						
1000B	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer
1000B	N1	N102	Premium Payer Name	Name identifying the organization remitting the payment	MED-QUEST	Name of organization making the payment.
1000B	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer ID Number

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
1000B	N1	N104	Premium Payer Identifier	Number identifying the organization remitting the payment	582479287	ACS Tax ID Number
Premium Payer's Address						
1000B	N3	N301	Premium Payer Address Line	Address line for the premium payer's address		Med-QUEST Street Address Line 1
1000B	N3	N302	Premium Payer Address Line 2	Address line 2 for the premium payer's address		Med-QUEST Street Address Line 2
Premium Payer's City, State, Zip						
1000B	N4	N401	Premium Payer City Name	The city name of the premium payer's address		Med-QUEST City
1000B	N4	N402	Premium Payer State Code	State postal code of the premium payer's address		Med-QUEST State
1000B	N4	N403	Premium Payer Postal Zone or ZIP Code	The postal zone code of the premium payer's address		Med-QUEST ZIP Code
Organization Summary Remittance Details						
2000A	ENT	ENT01	Assigned Number	Number assigned for differentiation within a transaction set.		Med-QUEST uses the 2000A Organization Summary Remittance Loop and the loops within it to show payment or withhold amounts that are not member specific. Settlement amounts, sanctions and partial payments are examples of how Med-QUEST can use the 2000A Loop. ENT01 is a unique number for each payment line within an 820 Transaction. Med-QUEST begins numeration with a "1" for the initial payment line of the 2000A Loop if a 2000A Loop is present. Sequential numeration continues through any additional 2000A lines and into 2000B lines if any are present.
2000A	ENT	ENT02	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	2L	Corporation/Organization Required if the 2000A Loop is present.
2000A	ENT	ENT03	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer ID Number Required if the 2000A Loop is present.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
2000A	ENT	ENT04	Organization Identification Code	The code identifying the organization providing the summary level premium remittance	996001089	DHS/Med-QUEST Federal Taxpayer ID Number Used for sanctions, negotiated settlements and other payments that are not member specific. Required if the 2000A Loop is present.
Organization Summary Remittance when ADJUSTMENT AMOUNTS are present						
2300A	RMR	RMR01	Reference Identification Qualifier	Code qualifying the reference identification	IK	Invoice Number Required if the 2000A Loop is present.
2300A	RMR	RMR02	Contract, Invoice, Account, Group, or Policy Number	The reference number to which this premium payment is associated, such as an account number, contract number, invoice number, group number, or policy number		The number of the invoice or voucher used to make the payment On 820 Transactions for medical health plans, the Invoice Number links payment lines to invoices issued by the ACS Financial System.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
2300A	RMR	RMR04	Detail Premium Payment Amount	Detailed remittance amount on the transaction		The amount of the payment (positive) or recovery (negative) On partial payment RMR Segments for which the partial payment is for detail payments that appear in other 2000A and/or 2000B Loops, RMR04 is a negative amount that represents the amount not covered by the partial payment. The ADX Segment is not needed. When the partial payment is for a payment amount within a particular 2000A Loop, the element is the full payment amount and a positive value in ADX01 is the difference between the full payment amount and the partial, actual payment. MQD sends some transactions with Voucher Numbers that contain zero amounts. Example: When MQD sends a termination that is effective on the last day of the current month, the 834 contains a Voucher Number with no recoupment. This is more of a notification. Similarly, when MQD sends a Rate Code Change on the last daily (effective the last day of the current month), a Voucher Number is included but has no dollar value.
Summary Line Item						
2310A	IT1	IT101	Line Item Control Number	Identifier assigned by the submitter/provider to this line item	1	The 2310A and 2315A Loops are required for “HIPAA health premium payments”, according to the Implementation Guide. Med-QUEST fills HIPAA required elements in the IT1 and SLN Segments with dummy values.
Member Count						
2315A	SLN	SLN01	Line Item Control Number	Identifier assigned by the submitter/provider to this line item		Within each payment, a sequential Line Numbers beginning with 1.
2315A	SLN	SLN03	Information Only Indicator	An indicator that this segment is informational only	O	Information
2315A	SLN	SLN04	Head Count	Number of members/insured under this summary line item remittance	0	Med-QUEST fills this required element with zero.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
2315A	SLN	SLN05-1	Unit for Measurement	Code specifying the units of which a value is being expressed, or manner in which a measurement has been taken	IE	Person (the unit of measurement for the SLN04 head count).
Organization Summary Remittance Level Adjustment						
2320A	ADX	ADX01	Adjustment Amount	If negative, [the Adjustment Amount] reduces the provider payment; if positive, it increases the provider payment		In partial-payment-within-a-2000A-Loop situations, this is a negative amount representing the amount withheld from the health plan's payment.
2320A	ADX	ADX02	Adjustment Reason Code	Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	H6	Partial Payment Med-QUEST makes use of the adjustment capability within the 2000A Loop to show partial payment of a Payment Amount within a particular 2000A Loop. For Med-QUEST, this is the only situation in which the ADX Segment appears on an 820 Transaction.
Individual Remittance						
2000B	ENT	ENT01	Assigned Number	Number assigned for differentiation within a transaction set		The 2300B Loop is for "detailed [i.e., member level] remittance information", including the per member payment amount for capitation pre-payments (Monthly 834s) and adjustments (Daily 834s and Mass Adjustments). ADX Segment Adjustments do not appear in the 2320B Loop within the 2000B Loop. Capitation adjustments to past health plan payments are expressed as separate 2000B Loops with their own positive or negative payment amounts. Within each 820 Transaction, ENT01 starts with 1 in the six-character Assigned Number element and increments by 1 for each member. The number in ENT01 in the 2000B Loop continues from final sanction line in the 2000A Loop if the 2000A Loop is present.
2000B	ENT	ENT02	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	2J	Individual

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
2000B	ENT	ENT03	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	ZZ	Mutually Defined Med-QUEST plans to use the HIPAA individual identifier when it is adopted.
2000B	ENT	ENT04	Receiver's Individual Identifier	The identification number of the individual used by the receiver		Member's HAWI/Med-QUEST ID
Individual Name						
2100B	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	QE	Policy Holder
2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100B	NM1	NM103	Individual Last Name	The last name of an individual to which specific remittance amount(s) apply		Member's Last Name Med-QUEST carries only 17 characters. If the LAST NAME is longer than 17 characters, Med-QUEST will only populate the first 17 characters
2100B	NM1	NM104	Individual First Name	The first name of an individual to whom specific remittance amounts apply		Member's First Name Med-QUEST carries only 10 characters. If the FIRST NAME is longer than 10 characters, Med-QUEST will populate the 10th position with an asterisk
2100B	NM1	NM105	Individual Middle Name	Middle name of an individual to whom specific remittance amounts apply		Member's Middle Initial
Individual Premium Remittance Detail						
2300B	RMR	RMR01	Reference Identification Qualifier	Code qualifying the reference identification	AZ	Health Insurance Policy Number

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
2300B	RMR	RMR02	Insurance Remittance Reference Number	The reference number for this individual premium remittance, such as a policy number, account number, invoice number		Information that identifies a payment line for an individual member. Med-QUEST strings the following fixed-length fields within RMR02 with its maximum of 30 characters: • Contract Type (X[1]) • Island Code (X[2]) • Rate Code (X[4]) • Voucher Number (X[9])
2300B	RMR	RMR04	Detail Premium Payment Amount	Detailed remittance amount on the transaction		This element carries the capitation pre-payment amount for each member on Monthly 834s. On Daily 834s, this element carries the payment amount, positive or negative, associated with the enrollment update. Both original payments and adjustments to past capitation payments appear in this element. The definition of an adjustment for the 820 Transaction is quite different from Med-QUEST's concept of capitation adjustments. The ADX Adjustment Segment is not used in the 2000B Loop.
Individual Coverage Period						
2300B	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	582	Report period
2300B	DTM	DTM05	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	Range of dates
2300B	DTM	DTM06	Coverage Period	The coverage period associated with this premium payment		Capitation Coverage Period for the member expressed in format CCYYMMDD – CCYYMMDD. On payments from Monthly 834s, the coverage period will be from the first to the last day of the pre-payment month. On payments from Daily 834s and mass adjustments, the period will be the period covered by the adjustment.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
Transaction Set Trailer						
N/A	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		Count of all segments between the ST and SE segments, including the ST and SE segments. Format is numeric from one to ten digits.
N/A		SE02	Transaction Set Control Number	The unique identification number within a transaction set		This number has the same value as data element ST02 at the beginning of the transaction.

6 Contacts

6.1 Systems Office (SO) Contacts

System	Primary
Help Desk	692-7953
Encounter	Wileen Ortega 692-7990
Provider	Wileen Ortega 692-7990
Health Plan Questions	Gene Nakahara 692-7991
VPN, Connectivity to MQD FTP, Logins	Network Support 692-7953

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

If your problem is critical to your operation, 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).

6.2 Membership File Integrity Section (MFIS) Contacts

MFIS is responsible for ensuring that eligibility information is consistent between HAWI and HPMMIS.

Health Plan	Contact	Phone Number
AlohaCare Medical	Jackie Faitau	692-7197
HMSA Medical	Holly Bryant	692-7194
HMSA Behavioral Health	Christine Akau	675-0608
HMSA Behavioral Health	Donna Broome	675-0610
Kaiser	Joyce Foster	692-7192
Summerlin	Nancy Barney	692-7193

Appendix A: Examples

A.1 Enrollment Corrections

Example 1: Erroneous Date of Birth

A newborn is initially enrolled on 05/09/00 based on the reported date of birth. The date of birth is subsequently verified to be 05/06/00. A block of enrollment is sent to the plan as an add transaction on a daily 834 for 05/06/00-05/08/00. The 820 will reflect capitation from 05/06/00-05/08/00.

Example 2: Erroneous Date of Death

Initially, the date of death is reported as 06/15/00. A disenrollment transaction is sent to the plan with an effective end date of 06/15/00. The date of death is subsequently corrected to 05/15/00. A block of disenrollment for 05/16/00-06/15/00 is sent to the plan as a disenroll transaction on a daily 834. The 820 will reflect a recoupment of capitation from 05/16/00-06/15/00.

Example 3: Foster Care Client Sent Out-of-State

A foster care client is enrolled with a plan and sent out-of-state midmonth on 06/17/00 and the client is placed in the fee-for-service program effective 06/17/00. A disenrollment transaction is sent to the plan effective 06/16/00 on a daily 834. The 820 will reflect a recoupment of capitation from 06/17/00-06/30/00.

A.2 Daily Capitation Calculations

Example: New Enrollment into QUEST

The system calculates a daily capitation based on the enrollment date. As an example, if an individual is enrolled into a QUEST plan, on 03/16/00, the plan receives an add transaction on a daily 834. The enroll begin date and the payment from date will be 03/16/00. There is no enroll end date, as the client is continuously eligible. The payment through date will be 03/31/00. The system calculates the capitation payment by dividing the appropriate QUEST rate by 31 (number of days in the month of March) times 16 days of enrollment. The result of this calculation will be reflected on the next 820 transaction.

Example: Recipient Changing from QUEST-Net to QUEST

The system recoups daily capitation and pays daily capitation based on the enrollment/ disenrollment. If an individual is QUEST-Net eligible and then becomes QUEST eligible, the plan will receive a separate disenrollment transaction from QUEST-Net and another enrollment transaction into QUEST on a daily 834. As an example, the enrollment with QUEST (same plan, but different rate code) is effective 03/16/00, thus the member is disenrolled from QUEST-Net effective 03/15/00. The system calculates and recoups the daily QUEST-Net rate for 16 days (03/16/00 through 03/31/00). The system also calculates and pays the daily QUEST rate for the same time period (03/16/00 through 03/31/00) on a separate transaction.

Example: Time Limits on Retroactive Capitation Adjustments

A time limitation applies to ongoing retroactive capitation payments and recoupments. MQD limits retroactive payments and recoupments to two contract years as long as the plan still has a contract with the state. The two contract years include the current and previous contract years (usually July 1 through June 30). For example, beginning July 1, 2001, there will be no retroactive payments or recoupments prior to July 1, 2000.

The following examples illustrate this approach. Assume that each individual remains eligible so that retroactive enrollment can be processed. For deaths, the disenrollment date is equal to the date of death.

Situation	Date Reported	Correct Enrollment/ Disenrollment Date	Payment/Recoupment Period Dates
Newborn	July 1, 2001	Birth date – June 30, 1999	July 1, 2000 to current month
Newborn	July 1, 2001	Birth date – June 30, 2000	July 1, 2000 to current month
Newborn	June 30, 2002	Birth date – July 1, 2001	July 1, 2001 to current month
Death	July 1, 2001	Date of death - June 30,1999	July 1, 2000 to current month
Death	July 1, 2001	Date of death - June 30, 2000	July 1, 2000 to current month
Death	June 30, 2002	Date of death - July 1, 2001	July 2, 2001 to current month

A.3 Payment From and Payment Through Dates

The Payment From Date can be retroactive (in the case of a newborn or a death). The Payment Through Date can never be greater than the end of the current processing month (until the monthly roster is created for the next month).

	Example 1: Newborn born 06/15/00 on 834 dated 07/19/00 (monthly cap = $230.00)	**Example 2: Date of Death of 05/10/00 on 834 dated 07/19/00 (monthly cap = $230.00)**
Action	021 – Addition	024 – Termination
Date of Death	Blank	20000510
Enroll Begin Date	20000615	Blank
Enroll End Date	Blank (open ended)	20000510 (equal to date of death)
Capitation Amount	00035267+ [(230 * (16/30)] + 230 (capitation payment for 16 of 30 days for June + full month for July)	00061581- ($155.81 partial recovery for May [(230/31)*21] + $230- recovery for full month of June + $230- recovery for full month of July)
Number of Days	047 (16 days in June + 31 days in July)	082 (21 days in May + 30 days in June + 31 days in July)
Payment From Date	20000615	20000511
Payment Through Date	20000731	20000731

Appendix B: Codes and Values

B.1 Ethnicity Codes

Ethnic Code	Description	HIPAA Code	HIPAA Description
AI	American Indian/Alaskan Native	I	American Indian or Alaskan Native
BL	Black (Not of Hispanic Origin)	N	Black (Non-Hispanic)
CH	Chinese	A	Asian or Pacific Islander
FI	Filipino	A	Asian or Pacific Islander
HA	Hawaiian (Include Part Hawaiian)	J	Native Hawaiian
HI	Hispanic (Include Puerto Rican)	H	Hispanic
JA	Japanese	A	Asian or Pacific Islander
KO	Korean	A	Asian or Pacific Islander
MI	Mixed	E	Other Race or Ethnicity
OA	Other Asians	A	Asian or Pacific Islander
OP	Other Pacific Islanders	P	Pacific Islander
OT	Other (Include HAWI Value of UN)	E	Other Race or Ethnicity
PR	Puerto Rican	H	Hispanic
SA	Samoan	P	Pacific Islander
UN	Unknown/Unspecified	7	Not Provided
WH	White (Not of Hispanic Origin)	O	White (Non-Hispanic)

B.2 Primary Language Codes

HPMMIS	
Language Code	**Description**
CHI	Chinese, Cantonese
ZHO	Chinese, Mandarin
ENG	English
HAW	Hawaiian
ILO	Filipino, Ilocano
JPN	Japanese
KMH	Cambodian
KOR	Korean
LAO	Laotian
PHI	Filipino, Other
SGN	Sign Language
SMO	Samoan
SPA	Spanish
TGL	Filipino, Tagalog
TON	Tongan
UND	South Pacific (other)
UND	Other
VIE	Vietnamese

B.3 Relationship Codes

HPMMIS			
Relationship Code	**From Date**	**To Date**	**Relationship**
AU	01/01/1986	99/99/9999	Aunt or uncle (include great/grand)
CH	01/01/1986	99/99/9999	Child
CL	01/01/1987	99/99/9999	Common–law spouse
CO	01/01/1986	99/99/9999	Cousin (first)
EX	01/01/1986	99/99/9999	Ex-spouse
FC	01/01/1986	99/99/9999	Foster child
GC	01/01/1986	99/99/9999	Grandchild/great grandchild
GR	01/01/1986	99/99/9999	Grandparent/great grandparent
HC	01/01/1990	99/99/9999	Hanai child
NN	01/01/1986	99/99/9999	Niece or nephew
NR	01/01/1986	99/99/9999	Not related
OR	01/01/1986	99/99/9999	Other – related
PA	01/01/1986	99/99/9999	Parent
PI	01/01/1986	99/99/9999	Primary information person
SC	01/01/1986	99/99/9999	Stepchild
SI	01/01/1986	99/99/9999	Sibling, includes half-bloods
SP	01/01/1986	99/99/9999	Spouse
SS	01/01/1986	99/99/9999	Step sibling
ST	01/01/1986	99/99/9999	Step parent
UB	01/01/1986	99/99/9999	Unborn child

B.4 TPL Codes

Note: The TPL codes in ***bold italics*** are Medicare codes that are used to generate the Medicare records in HPMMIS.
Codes marked as "Not a true TPL" are either not valid for QUEST members or do not truly represent other medical/behavioral health coverage. Plans should pay for services provided to members with these TPL codes.

TPL Code	Description	NOT a true TPL	Do not use after:
2A	Kaiser Health Plan (Medical)		
2B	Kaiser Health Plan (Vision)		
5A	HMSA Health Plan Hawaii (Med Only) – HMO		
5B	HMSA Health Plan Hawaii (Hosp/Med/Dental)		
A1	University Alliance (Hosp/Med/Drug/Vision)		
A2	University Alliance (Medical)		
A3	University Alliance (Vision)		
AC	Aloha Care Advantage		
AN	Aloha Care QUEST-Net	**X**	**11/30/2000**
AQ	Aloha Care QUEST-Net – Oahu	**X**	**11/30/2000**
AR	Aloha Care QUEST-Net – Kauai	**X**	**11/30/2000**
AS	Aloha Care QUEST-Net – E. Hawaii	**X**	**11/30/2000**
AT	Aloha Care QUEST-Net – W. Hawaii	**X**	**11/30/2000**
BF	Federal Breast Cancer Program	**X**	
BN	Queen's Hawaii Care QUEST-Net	**X**	**11/30/2000**
BQ	Queen's Hawaii Care QUEST-Net – Oahu	**X**	**11/30/2000**
BS	Queen's Hawaii Care QUEST-Net – E. Hawaii	**X**	**11/30/2000**
BT	Queen's Hawaii Care QUEST-Net – W. Hawaii	**X**	**11/30/2000**
BV	Queen's Hawaii Care QUEST-Net – Molokai	**X**	**11/30/2000**
C1	CIGNA Health Care (Dental/Vision)		
C2	CIGNA Health Care		
CC	Community Care Services		

TPL Code	Description	NOT a true TPL	Do not use after:
CF	Federal Cervical Cancer Program	X	
CG	CIGNA Health Care		
CN	HMSA – QUEST-Net	X	
CQ	HMSA – QUEST-Net - Oahu	X	**11/30/2000**
CR	HMSA – QUEST-Net – Kauai	X	**11/30/2000**
CS	HMSA – QUEST-Net – E. Hawaii	X	**11/30/2000**
CT	HMSA – QUEST-Net – W. Hawaii	X	**11/30/2000**
CU	HMSA – QUEST-Net – Maui	X	**11/30/2000**
CV	CHAMPVA – Civil Health/Med Pgm Vet Affairs		
CW	HMSA – QUEST-Net – Lanai	X	**11/30/2000**
DM	Demo Project Pay Drug Co-Pay		
DN	Kaiser QUEST-Net	X	
DQ	Kaiser QUEST-Net – Oahu	X	**11/30/2000**
DU	Kaiser QUEST-Net – Maui	X	**11/30/2000**
E1	HI Electricians (Medical/Drug)		
EN	Straub QUEST-Net	X	**11/30/2000**
EQ	Straub QUEST-Net – Oahu	X	**11/30/2000**
EW	Straub QUEST-Net – Lanai	X	**11/30/2000**
GN	Kapiolani Health Hawaii QUEST-Net	X	**11/30/2000**
GQ	Kapiolani Health Hawaii QUEST-Net – Oahu	X	**11/30/2000**
GR	Kapiolani Health Hawaii QUEST-Net – Kauai	X	**11/30/2000**
GS	Kapiolani Health Hawaii QUEST-Net – E HI	X	**11/30/2000**
GT	Kapiolani Health Hawaii QUEST-Net – W HI	X	**11/30/2000**
H1	HMAA (Dental Only)		
H2	HMAA (Medical & Drug)		
H3	HMAA (Med/Dental/Vision/Drug)		
H4	HMAA (Vision Only)		
HA	HMAA (Medical Only)		
HD	Hawaii State Health Fund Dental Plan		
HE	HI Electricians (Hosp/Med/Drug/Vision)		

TPL Code	Description	NOT a true TPL	Do not use after:
HL	Hawaii Laborers Self Insured Plan		
HM	HDS – Medical, Drug, Vision		**5/31/1995**
HP	Hawaii State Health Fund Drug Plan		
HV	Hawaii State Health Fund Vision Plan		
HX	HMSA Drug Only (No Medical)		
HZ	HMSA Vision Only (No Medical)		
IF	State-Funded Immigrant Children - FFS	**X**	**12/31/2000**
IN	Inmate Inpatient	**X**	
IQ	State-Funded Immigrant Children - QUEST	**X**	**12/31/2000**
K1	Kaiser Permanente Senior (Vision)		
K2	Kaiser Permanente Senior (Hosp/Med/Vision/Drug)		
KF	Title XXI Fee-For-Service	**X**	**12/31/2000**
KP	Kapiolani Health Hawaii		**6/30/2001**
KQ	Title XXI - QUEST	**X**	**12/31/2000**
KS	Kaiser Permanente Senior Plan		
LM	Longs Medical Plan		
M1	HMA, Inc. (Medical Only)		
M2	HMA, Inc. (Medical & Drug)		
M3	HMA, Inc. (Vision Only)		
MB	Children Behavior Health - DOH	**X**	**11/30/2000**
OT	Other – TPL other than a Medical Plan	**X**	
PA	PACE (Program Of All Inclusive Care Elderly)		
PC	Penal Contract	**X**	
***PM**	***Paid Medicare A***		
SB	State Breast Cancer Program	**X**	
SC	State Cervical Cancer Program	**X**	
SH	SHIP/HMSA		**7/31/1994**
SK	SHIP/Kaiser		**7/31/1994**
SU	Summerlin Life & Health Insurance		
TA	TriCare for Life (Hosp/Med/Drugs)		
TD	TriCare for Life (Dental Only)		

TPL Code	Description	NOT a true TPL	Do not use after:
TN	Aloha Care Dental – QUEST-Net	**X**	**11/30/2000**
TV	TriCare for Life (Vision)		
TW	Triwest (Hosp/Med/Drugs)		
U1	United Health Care (Medical)		
U2	United Health Care (Drug)		
U3	United Health Care – Evercare (Medical)		
UA	University Alliance		
UC	United Concordia (Dental)		
UH	United Health Care		
VS	Vision Service Plan		
W1	Triwest (Hosp/Medical)		
W2	Triwest (Vision)		
W3	Triwest (Dental)		
WN	HMSA Dental QUEST-Net	**X**	**11/30/2000**
YN	Denticare QUEST-Net	**X**	**11/30/2000**
01	Aetna Life Insurance		
02	AFL-CIO Hotel and Restaurant Health Fund		
03	American National		
04	Banker's Life and Casualty		
05	Blue Cross/Blue Shield		
06	California Western Life		
07	TriCare for Life (Hosp/Medical)		
08	Combined Insurance		
09	Connecticut General Life		
10	Continental Casualty		
11	Equitable Life Assurance Society		
12	Equitable Life and Casualty		
13	Fireman's Fund Insurance		
14	General American Life		
15	John Hancock Mutual		
16	Hawaii Dental Service		
17	HMSA (Medical Only)		
18	HMSA 65C		
19	HMSA – Community Health Program		

TPL Code	Description	NOT a true TPL	Do not use after:
20	Kaiser Health Plan		
21	Kaiser Project Client (KaiPro)		**7/31/1994**
22	Liberty Life Assurance		
23	Lincoln National Life		
***24**	***Medicare A Only***		
***25**	***Medicare B Only***		
***26**	***Medicare A and B***		
27	Metropolitan Life		
28	Mutual of Omaha		
29	New York Life		
30	Occidental Life		
31	Paul Revere Life		
32	Physicians Mutual Life		
33	Prudential Insurance		
34	Sears Employee Plan		
35	Traveler's Insurance		
36	Union Fidelity		
37	Va – Service Connected Disability		
38	Worker's Compensation		
39	Military Facility (MilFac)		
40	Plantation Medical Plan		
41	Subrogation for Accident (Init Form 1125)	**X**	
42	HMSA With Dental Plan		
43	Academy Life Insurance		
44	Allstate Medical Plan		
46	Island Care		**12/31/2002**
47	HMSA with Drug Plan		
48	HMSA with Drug/Vision Plan		
49	HMSA with Dental/Drug/Vision Plan		
50	HMSA Dental Plan Only		
51	HMSA Health Plan Hawaii		
52	Private Motor Vehicle Insurance		
53	Kaiser Drug Plan		
54	Am Family (Aflac)		
55	HMSA – 65C Plus		

TPL Code	Description	NOT a true TPL	Do not use after:
56	Alpha Omega Corporation		
57	American Income Life		
58	American Patriot Health Insurance		
59	American Association of Retired Persons (AARP)		
60	Bay Area Painters' Welfare Plan		
61	Beneficial Standard Insurance		
62	Best Care		
63	California Association of Resolute Employees (CARE)		
64	California Pacific Life		
65	Colonial Penn		
66	Delta Dental Plan		
67	Deseret Mutual		
68	Farm and Home Life Insurance Company		
69	Federal Employee Health and Welfare Plan		
70	Galbraith and Green		
71	Greatwest Life Assurance Company		
72	Hawaii Carpenters Health and Welfare Program		
73	HGEA Dental		
74	International Prescription – Clearing House		
75	Mail Handlers Benefit Plan		
76	National Association of Letter Carriers		
77	National Benefit Life		
78	National Fidelity Life		
79	National Home Life		
80	Northbrook Life Insurance		
81	Operating Engineers Health and Welfare Plan		
82	Oral Health Services of Hawaii		
83	Pacific Mutual		

TPL Code	Description	NOT a true TPL	Do not use after:
84	Pay-n-Save Medical		
85	Pensioned Health and Welfare Trust Fund		
86	PECA – IBEW		
87	Phoenix Mutual Life		
88	Queen's Health Care Plan		
89	Roofers Prescription Plan		
90	Seafarer Welfare Plan		
91	Senior's Straub Plan		**6/30/2000**
92	Southland Medical Insurance		
93	Teamsters Health and Welfare Plan		
94	United Veterans Group Insurance Trust		
95	Valley Clerks Trust Fund		
96	PA Case-Refuses To Comply 1125/1125A Req		
97	Western Airlines Health Care		
98	Other (Submit Form 1126)		

***** Medicare codes that are used to generate the Medicare records in HPMMIS

B.5 Type of TPL Coverage Codes

Code	Description
A	Medical/Dental
B	Medical/Drugs
C	Medical/Vision
D	Medical/Dental/Drugs
E	Medical/Dental/Drugs/Vision
F	Medical/Dental/Vision
G	Medical/Drugs/Vision
M	Dental/Drugs
N	Dental/Vision
S	Drugs/Vision
1	Medical only
2	Dental only
3	Drugs only
4	Vision only
5	Hospital only
6	Behavioral Health only

B.6 Health Plan IDs

Medical Plan Code	Description
ALOHAC	AlohaCare - Medical
HMSAAA	HMSA - Medical
KAISER	Kaiser - Medical
SUMMER	Summerlin - Medical

Behavioral Health Plan Code	Description
CAMHDA	CAMHD
DOHEIP	DOH Early Intervention Program
HMSABH	HMSA Behavioral Health

B.7 Island Codes

Island Code	Island
01	Oahu
04	Kauai
05	Hawaii (06 will not be used)
07	Maui
08	Molokai
09	Lanai

B.8 Rate Code Summary

Rate Code	Rate Code Description	Rate Code Begin	Rate Code End
7000	BEHAVIORAL HEALTH SERVICES-FELIX (3-20)	08/01/1994	99/99/9999
7100	BHS - SMI WITH MEDICARE (18+)	08/01/1994	99/99/9999
7110	BHS - SMI WITHOUT MEDICARE (18+)	08/01/1994	99/99/9999
7700	BEHAVIORAL HEALTH SERVICES-EIP (0-2)	08/01/1994	99/99/9999
8020	QMB ONLY	08/01/1994	99/99/9999
8400	SLMB	08/01/1994	99/99/9999
8700	QDWI - QUALIFIED DISABLED WORKING INDIVIDUALS	08/01/1994	99/99/9999
8800	REPATRIATE	08/01/1994	99/99/9999
8900	STATE FUNDED - PENSIONER	08/01/1994	99/99/9999
AA00	AGED WITH MEDICARE	08/01/1994	99/99/9999
AA10	AGED WITHOUT MEDICARE	08/01/1994	99/99/9999
AF01	BLIND/DISABLED FEMALE < 1 WITH MEDICARE	08/01/1994	99/99/9999
AF02	BLIND/DISABLED FEMALE 1-5 WITH MEDICARE	08/01/1994	99/99/9999
AF03	BLIND/DISABLED FEMALE 6-11 WITH MEDICARE	08/01/1994	99/99/9999
AF04	BLIND/DISABLED FEMALE 12-18 WITH MEDICARE	08/01/1994	99/99/9999
AF05	BLIND/DISABLED FEMALE 19-20 WITH MEDICARE	08/01/1994	99/99/9999
AF06	BLIND/DISABLED FEMALE 21-39 WITH MEDICARE	08/01/1994	99/99/9999
AF07	BLIND/DISABLED FEMALE 40-64 WITH MEDICARE	08/01/1994	99/99/9999
AF11	BLIND/DISABLED FEMALE < 1 WITHOUT MEDICARE	08/01/1994	99/99/9999
AF12	BLIND/DISABLED FEMALE 1-5 WITHOUT MEDICARE	08/01/1994	99/99/9999
AF13	BLIND/DISABLED FEMALE 6-11 WITHOUT MEDICARE	08/01/1994	99/99/9999
AF14	BLIND/DISABLED FEMALE 12-18 WITHOUT MEDICARE	08/01/1994	99/99/9999
AF15	BLIND/DISABLED FEMALE 19-20 WITHOUT MEDICARE	08/01/1994	99/99/9999
AF16	BLIND/DISABLED FEMALE 21-39 WITHOUT MEDICARE	08/01/1994	99/99/9999
AF17	BLIND/DISABLED FEMALE 40-64 WITHOUT MEDICARE	08/01/1994	99/99/9999
AM01	BLIND/DISABLED MALE < 1 WITH MEDICARE	08/01/1994	99/99/9999
AM02	BLIND/DISABLED MALE 1-5 WITH MEDICARE	08/01/1994	99/99/9999

Rate Code	Rate Code Description	Rate Code Begin	Rate Code End
AM03	BLIND/DISABLED MALE 6-11 WITH MEDICARE	08/01/1994	99/99/9999
AM04	BLIND/DISABLED MALE 12-18 WITH MEDICARE	08/01/1994	99/99/9999
AM05	BLIND/DISABLED MALE 19-20 WITH MEDICARE	08/01/1994	99/99/9999
AM06	BLIND/DISABLED MALE 21-39 WITH MEDICARE	08/01/1994	99/99/9999
AM07	BLIND/DISABLED MALE 40-64 WITH MEDICARE	08/01/1994	99/99/9999
AM11	BLIND/DISABLED MALE <1 WITHOUT MEDICARE	08/01/1994	99/99/9999
AM12	BLIND/DISABLED MALE 1-5 WITHOUT MEDICARE	08/01/1994	99/99/9999
AM13	BLIND/DISABLED MALE 6-11 WITHOUT MEDICARE	08/01/1994	99/99/9999
AM14	BLIND/DISABLED MALE 12-18 WITHOUT MEDICARE	08/01/1994	99/99/9999
AM15	BLIND/DISABLED MALE 19-20 WITHOUT MEDICARE	08/01/1994	99/99/9999
AM16	BLIND/DISABLED MALE 21-39 WITHOUT MEDICARE	08/01/1994	99/99/9999
AM17	BLIND/DISABLED MALE 40-64 WITHOUT MEDICARE	08/01/1994	99/99/9999
CF11	CHIP FEMALE <1	07/01/2000	99/99/9999
CF12	CHIP FEMALE 1-5	07/01/2000	99/99/9999
CF13	CHIP FEMALE 6-11	07/01/2000	99/99/9999
CF14	CHIP FEMALE 12-18	07/01/2000	99/99/9999
CM11	CHIP MALE <1	07/01/2000	99/99/9999
CM12	CHIP MALE 1-5	07/01/2000	99/99/9999
CM13	CHIP MALE 6-11	07/01/2000	99/99/9999
CM14	CHIP MALE 12-18	07/01/2000	99/99/9999
EF15	QUEST ACE FEMALE 19-20	03/01/2007	99/99/9999
EF16	QUEST ACE FEMALE 21-39	03/01/2007	99/99/9999
EF17	QUEST ACE FEMALE 40+	03/01/2007	99/99/9999
EF18	QUEST ACE FEMALE 65+	01/01/2008	99/99/9999
EM15	QUEST ACE MALE 19-20	03/01/2007	99/99/9999
EM16	QUEST ACE MALE 21-39	03/01/2007	99/99/9999
EM17	QUEST ACE MALE 40+	03/01/2007	99/99/9999
EM18	QUEST ACE MALE 65+	01/01/2008	99/99/9999
ES00	EMERGENCY SERVICES FOR ALIENS	08/01/1994	99/99/9999
FF10	FEDERAL-FUNDED BCC	07/01/2001	99/99/9999
FF11	FOSTER CARE FEMALE < 1	08/01/1994	99/99/9999

Rate Code	Rate Code Description	Rate Code Begin	Rate Code End
FF12	FOSTER CARE FEMALE 1-5	08/01/1994	99/99/9999
FF13	FOSTER CARE FEMALE 6-11	08/01/1994	99/99/9999
FF14	FOSTER CARE FEMALE 12-18	08/01/1994	99/99/9999
FF15	FOSTER CARE FEMALE 19+	08/01/1994	99/99/9999
FM11	FOSTER CARE MALE < 1	08/01/1994	99/99/9999
FM12	FOSTER CARE MALE 1-5	08/01/1994	99/99/9999
FM13	FOSTER CARE MALE 6-11	08/01/1994	99/99/9999
FM14	FOSTER CARE MALE 12-18	08/01/1994	99/99/9999
FM15	FOSTER CARE MALE 19+	08/01/1994	99/99/9999
G000	DEMONSTRATION GRANT MEDICAL	09/01/2006	99/99/9999
GC00	MEDICAL DEMONSTRATION GRANT CONTROL GROUP	09/01/2006	99/99/9999
GF14	ST FINCL GEN ASST FEMALE 12 - 18	08/01/1994	99/99/9999
GF15	ST FINCL GEN ASST FEMALE 19 - 20	08/01/1994	99/99/9999
GF16	ST FINCL GEN ASST FEMALE 21 - 39	08/01/1994	99/99/9999
GF17	ST FINCL GEN ASST FEMALE 40+	08/01/1994	99/99/9999
GM14	ST FINCL GEN ASST MALE 12 - 18	08/01/1994	99/99/9999
GM15	ST FINCL GEN ASST MALE 19 - 20	08/01/1994	99/99/9999
GM16	ST FINCL GEN ASST MALE 21 - 39	08/01/1994	99/99/9999
GM17	ST FINCL GEN ASST MALE 40+	08/01/1994	99/99/9999
HF11	HYBRID/QUEST NET FEMALE < 1	10/01/2006	99/99/9999
HF12	HYBRID/QUEST NET FEMALE 1 – 5	10/01/2006	99/99/9999
HF13	HYBRID/QUEST NET FEMALE 6 – 11	10/01/2006	99/99/9999
HF14	HYBRID/QUEST NET FEMALE 12 18	10/01/2006	99/99/9999
HM11	HYBRID/QUEST NET MALE < 1	10/01/2006	99/99/9999
HM12	HYBRID/QUEST NET MALE 1 – 5	10/01/2006	99/99/9999
HM13	HYBRID/QUEST NET MALE 6 – 11	10/01/2006	99/99/9999
HM14	HYBRID/QUEST NET MALE 12-18	10/01/2006	99/99/9999
IF11	IMMIGRANT CHILD FEMALE <1	07/01/2000	99/99/9999
IF12	IMMIGRANT CHILD FEMALE 1-5	07/01/2000	99/99/9999
IF13	IMMIGRANT CHILD FEMALE 6-11	07/01/2000	99/99/9999
IF14	IMMIGRANT CHILD FEMALE 12-18	07/01/2000	99/99/9999
IM11	IMMIGRANT CHILD MALE <1	07/01/2000	99/99/9999

Rate Code	Rate Code Description	Rate Code Begin	Rate Code End
IM12	IMMIGRANT CHILD MALE 1-5	07/01/2000	99/99/9999
IM13	IMMIGRANT CHILD MALE 6-11	07/01/2000	99/99/9999
IM14	IMMIGRANT CHILD MALE 12-18	07/01/2000	99/99/9999
IP14	IMMIGRANT PREGNANT WOMAN B/D UNDER 19	07/01/2004	99/99/9999
IP15	IMMIGRANT PREGNANT WOMAN B/D 19-20	07/01/2004	99/99/9999
IP16	IMMIGRANT PREGNANT WOMAN B/D 21-39	07/01/2004	99/99/9999
IP17	IMMIGRANT PREGNANT WOMAN B/D 40 - 64	07/01/2004	99/99/9999
IQ14	IMMIGRANT PREGNANT WOMAN UNDER 19	07/01/2004	99/99/9999
IQ15	IMMIGRANT PREGNANT WOMAN 19 – 20	07/01/2004	99/99/9999
IQ16	IMMIGRANT PREGNANT WOMAN 21 – 39	07/01/2004	99/99/9999
IQ17	IMMIGRANT PREGNANT WOMAN 40 - 64	07/01/2004	99/99/9999
JF11	IMMIGRANT CHILD BLIND/DISABL FEMAL <1	07/01/2000	99/99/9999
JF12	IMMIGRANT CHILD BLIND/DISABL FEMAL 1-5	07/01/2000	99/99/9999
JF13	IMMIGRANT CHILD BLIND/DISABL FEMAL 6-11	07/01/2000	99/99/9999
JF14	IMMIGRANT CHILD BLIND/DISABL FEMAL 12-18	07/01/2000	99/99/9999
JM11	IMMIGRANT CHILD BLIND/DISABL MALE <1	07/01/2000	99/99/9999
JM12	IMMIGRANT CHILD BLIND/DISABL MALE 1-5	07/01/2000	99/99/9999
JM13	IMMIGRANT CHILD BLIND/DISABL MALE 6-11	07/01/2000	99/99/9999
JM14	IMMIGRANT CHILD BLIND/DISABL MALE 12-18	07/01/2000	99/99/9999
KF11	CHIP - BLIND/DISABLED FEMALE <1	07/01/2000	99/99/9999
KF12	CHIP - BLIND/DISABLED FEMALE 1-5	07/01/2000	99/99/9999
KF13	CHIP - BLIND/DISABLED FEMALE 6-11	07/01/2000	99/99/9999
KF14	CHIP - BLIND/DISABLED FEMALE 12-18	07/01/2000	99/99/9999
KM11	CHIP - BLIND/DISABLED MALE <1	07/01/2000	99/99/9999
KM12	CHIP - BLIND/DISABLED MALE 1-5	07/01/2000	99/99/9999
KM13	CHIP - BLIND/DISABLED MALE 6-11	07/01/2000	99/99/9999
KM14	CHIP - BLIND/DISABLED MALE 12-18	07/01/2000	99/99/9999
NF11	QUEST NET FEMALE <1	04/01/1996	99/99/9999
NF12	QUEST NET FEMALE 1-5	04/01/1996	99/99/9999
NF13	QUEST NET FEMALE 6-11	04/01/1996	99/99/9999
NF14	QUEST NET FEMALE 12-18	04/01/1996	99/99/9999
NF15	QUEST NET FEMALE 19-20	04/01/1996	99/99/9999

Rate Code	Rate Code Description	Rate Code Begin	Rate Code End
NF16	QUEST NET FEMALE 21-39	04/01/1996	99/99/9999
NF17	QUEST NET FEMALE 40-64	04/01/1996	99/99/9999
NF18	QUEST NET FEMALE 65+	04/01/1996	99/99/9999
NM11	QUEST NET MALE <1	04/01/1996	99/99/9999
NM12	QUEST NET MALE 1-5	04/01/1996	99/99/9999
NM13	QUEST NET MALE 6-11	04/01/1996	99/99/9999
NM14	QUEST NET MALE 12-18	04/01/1996	99/99/9999
NM15	QUEST NET MALE 19-20	04/01/1996	99/99/9999
NM16	QUEST NET MALE 21-39	04/01/1996	99/99/9999
NM17	QUEST NET MALE 40-64	04/01/1996	99/99/9999
NM18	QUEST NET MALE 65+	04/01/1996	99/99/9999
P000	PUBLIC SAFETY DIVISION MEDICAL	08/01/1994	99/99/9999
PF01	MEDICAID PRISONER FEMALE < 1 WITH MEDICARE	08/01/2001	99/99/9999
PF02	MEDICAID PRISONER FEMALE 1-5 WITH MEDICARE	08/01/2001	99/99/9999
PF03	MEDICAID PRISONER FEMALE 6-11 WITH MEDICARE	08/01/2001	99/99/9999
PF04	MEDICAID PRISONER FEMALE 12-18 WITH MEDICAR	08/01/2001	99/99/9999
PF05	MEDICAID PRISONER FEMALE 19-20 WITH MEDICAR	08/01/2001	99/99/9999
PF06	MEDICAID PRISONER FEMALE 21-39 WITH MEDICAR	08/01/2001	99/99/9999
PF07	MEDICAID PRISONER FEMALE 40-64 WITH MEDICAR	08/01/2001	99/99/9999
PF11	MEDICAID PRISONER FEMALE < 1 WITHOUT MEDICA	08/01/2001	99/99/9999
PF12	MEDICAID PRISONER FEMALE 1-5 WITHOUT MEDICA	08/01/2001	99/99/9999
PF13	MEDICAID PRISONER FEMALE 6-11 WITHOUT MEDIC	08/01/2001	99/99/9999
PF14	MEDICAID PRISONER FEMALE 12-18 WITHOUT MEDI	08/01/2001	99/99/9999
PF15	MEDICAID PRISONER FEMALE 19-20 WITHOUT MEDI	08/01/2001	99/99/9999
PF16	MEDICAID PRISONER FEMALE 21-39 WITHOUT MEDI	08/01/2001	99/99/9999
PF17	MEDICAID PRISONER FEMALE 40-64 WITHOUT MEDI	08/01/2001	99/99/9999
PM01	MEDICAID PRISONER MALE < 1 WITH MEDICARE	08/01/2001	99/99/9999

Rate Code	Rate Code Description	Rate Code Begin	Rate Code End
PM02	MEDICAID PRISONER MALE 1-5 WITH MEDICARE	08/01/2001	99/99/9999
PM03	MEDICAID PRISONER MALE 6-11 WITH MEDICARE	08/01/2001	99/99/9999
PM04	MEDICAID PRISONER MALE 12-18 WITH MEDICARE	08/01/2001	99/99/9999
PM05	MEDICAID PRISONER MALE 19-20 WITH MEDICARE	08/01/2001	99/99/9999
PM06	MEDICAID PRISONER MALE 21-39 WITH MEDICARE	08/01/2001	99/99/9999
PM07	MEDICAID PRISONER MALE 40-64 WITH MEDICARE	08/01/2001	99/99/9999
PM11	MEDICAID PRISONER MALE < 1 WITHOUT MEDICARE	08/01/2001	99/99/9999
PM12	MEDICAID PRISONER MALE 1-5 WITHOUT MEDICARE	08/01/2001	99/99/9999
PM13	MEDICAID PRISONER MALE 6-11 WITHOUT MEDICARE	08/01/2001	99/99/9999
PM14	MEDICAID PRISONER MALE 12-18 WITHOUT MEDICARE	08/01/2001	99/99/9999
PM15	MEDICAID PRISONER MALE 19-20 WITHOUT MEDICARE	08/01/2001	99/99/9999
PM16	MEDICAID PRISONER MALE 21-39 WITHOUT MEDICARE	08/01/2001	99/99/9999
PM17	MEDICAID PRISONER MALE 40-64 WITHOUT MEDICARE	08/01/2001	99/99/9999
QF11	HAWAII QUEST FEMALE <1	08/01/1994	99/99/9999
QF12	HAWAII QUEST FEMALE 1-5	08/01/1994	99/99/9999
QF13	HAWAII QUEST FEMALE 6-11	08/01/1994	99/99/9999
QF14	HAWAII QUEST FEMALE 12-18	08/01/1994	99/99/9999
QF15	HAWAII QUEST FEMALE 19-20	08/01/1994	99/99/9999
QF16	HAWAII QUEST FEMALE 21-39	08/01/1994	99/99/9999
QF17	HAWAII QUEST FEMALE 40-64	08/01/1994	99/99/9999
QM11	HAWAII QUEST MALE <1	08/01/1994	99/99/9999
QM12	HAWAII QUEST MALE 1-5	08/01/1994	99/99/9999
QM13	HAWAII QUEST MALE 6-11	08/01/1994	99/99/9999
QM14	HAWAII QUEST MALE 12-18	08/01/1994	99/99/9999
QM15	HAWAII QUEST MALE 19-20	08/01/1994	99/99/9999
QM16	HAWAII QUEST MALE 21-39	08/01/1994	99/99/9999
QM17	HAWAII QUEST MALE 40-64	08/01/1994	99/99/9999
QS00	QUEST SPEND DOWN	04/01/1996	99/99/9999

Rate Code	Rate Code Description	Rate Code Begin	Rate Code End
SF10	STATE-FUNDED BCC	07/01/2001	99/99/9999
TF11	AFDC/TANF FEMALE <1	08/01/1994	99/99/9999
TF12	AFDC/TANF FEMALE 1-5	08/01/1994	99/99/9999
TF13	AFDC/TANF FEMALE 6-11	08/01/1994	99/99/9999
TF14	AFDC/TANF FEMALE 12-18	08/01/1994	99/99/9999
TF15	AFDC/TANF FEMALE 19-20	08/01/1994	99/99/9999
TF16	AFDC/TANF FEMALE 21-39	08/01/1994	99/99/9999
TF17	AFDC/TANF FEMALE 40-64	08/01/1994	99/99/9999
TM11	AFDC/TANF MALE <1	08/01/1994	99/99/9999
TM12	AFDC/TANF MALE 1-5	08/01/1994	99/99/9999
TM13	AFDC/TANF MALE 6-11	08/01/1994	99/99/9999
TM14	AFDC/TANF MALE 12-18	08/01/1994	99/99/9999
TM15	AFDC/TANF MALE 19-20	08/01/1994	99/99/9999
TM16	AFDC/TANF MALE 21-39	08/01/1994	99/99/9999
TM17	AFDC/TANF MALE 40-64	08/01/1994	99/99/9999
Y000	OFFICE OF YOUTH SERVICE MEDICAL	08/01/1994	99/99/9999

B.9 Maintenance Type Codes and Action Codes

Plans should use Maintenance Type Codes to process a record. Maintenance types include:

- 021 – Addition
- 001 – Change
- 024 – Termination
- 030 – Audit/Compare

Action codes are included on the daily 834 to provide the health plans with additional transaction information.

Action Codes for Change Maintenance Type Records
Multiple maintenance codes can be sent on a change maintenance type record. Change record maintenance codes indicate which client data fields have been changed since the last daily 834 was sent to the plan.

To assist medical and behavioral health plans with the coordination of behavioral health services, changes to behavioral health enrollment are provided on the daily 834. The change (e.g., enrollment in or disenrollment from a behavioral health plan) results in a change maintenance record to the client's medical health plan. Similarly, changes to a medical health plan result in a change maintenance record to the behavioral health plan. Changes to other plan enrollments (i.e., notification to a medical plan regarding a change to a dental plan enrollment) are not sent on a daily 834. Plans can obtain this information on the monthly 834.

Action Codes for Addition and Termination Maintenance Type Records
Only one action code is sent for an Addition or Termination maintenance type record. Because there could be more than one reason for adding or deleting the enrollment, plans should use the action code for informational purposes only (i.e. to gather statistics on their enrollment). When an addition or termination record is received, the plan should update their system for all fields on the daily 834.

Addition and Termination Transactions for Inter-Island Change in Residency
In addition to the Address Change transactions, HPMMIS creates termination and addition transactions when clients change their island of residence.

For Behavioral health plans, these termination and addition transactions normally occur on the last daily at the end of the month. Because behavioral health plans currently provide statewide services, these should have a zero net affect on the plan.

Medical and dental plans will receive a termination when clients change their island of residence. However, for medical plans, clients are offered the opportunity to select a new medical plan based on the plans available on their new island; therefore, medical plans may not receive an add enroll transaction for these clients.

Addition Maintenance Types			
Maintenance Type	**Action Code**	**Description**	**Maintenance Reason Code/Definition**
021	AA	Algorithm Assigned	28 – Initial Enrollment
021	AI	Admin–In	28 – Initial Enrollment
021	BI	Enrollment Block In	28 – Initial Enrollment
021	CI	County Move–In	28 – Initial Enrollment
021	EC	Enrollment Choice	28 – Initial Enrollment
021	EI	Open Enrollment–In	22 – Plan Change
021	NB	Newborn	02 – Birth
021	NE	Normal Enrollment	28 – Initial Enrollment
021	PA	End of contract-in: Auto assign	22 – Plan Change
021	RA	Retroactive Enrollment	28 – Initial Enrollment
021	RE	Re–Enrollment	41 – Re–enrollment

Change Maintenance Types			
Maintenance Type	**Action Code**	**Description**	**Maintenance Reason Code/Definition**
001	AC	Address Change	43 – Change of Location
001	C1	"Combination Action Code" ~ DB, NC, SX	25 – Change in Identifying Data Element
001	C2	"Combination Action Code" ~ DB, NC	25 – Change in Identifying Data Element
001	C3	"Combination Action Code" ~ DB, SX	25 – Change in Identifying Data Element
001	C4	"Combination Action Code" ~ NC, SX	25 – Change in Identifying Data Element
001	DB	Date of Birth Change	25 – Change in Identifying Data Element
001	HC	Acute Health Plan Change	22 – Plan Change
001	MC	Mental Health Change	22 – Plan Change
001	NC	Name Change	25 – Change in Identifying Data Element
001	OC	Other Change	33 – Personnel Data
001	PG	Pregnant Women	21 – Disability
001	RC	Rate Code Change	29 – Benefit Selection
001	SC	Share of Cost Change	Not Used by Med–QUEST
001	SX	Sex Change	25 – Change in Identifying Data Element
001	TM	Mental Health Termination	07 – Termination of Benefits

Termination Maintenance Types			
Maintenance Type	**Action Code**	**Description**	**Maintenance Reason Code/Definition**
024	AG	Age Termination	07 – Termination of Benefits
024	AO	Admin Out	07 – Termination of Benefits
024	BO	Enrollment Block Out	07 – Termination of Benefits
024	CH	Eligibility Change – Disenroll	07 – Termination of Benefits
024	CO	County Move–Out	07 – Termination of Benefits
024	DE	Deceased	03 – Death
024	EO	Open Enrollment–Out	22 – Plan Change
024	IE	Ineligible	07 – Termination of Benefits
024	IN	Incarcerated/Institutionalized	07 – Termination of Benefits
024	OS	Out of State Move	07 – Termination of Benefits
024	PT	End of contract-out: %, auto, rule	22 – Plan Change
024	RD	Retroactive Disenrollment	07 – Termination of Benefits
024	VW	Voluntary Withdrawal	14 – Voluntary Withdrawal