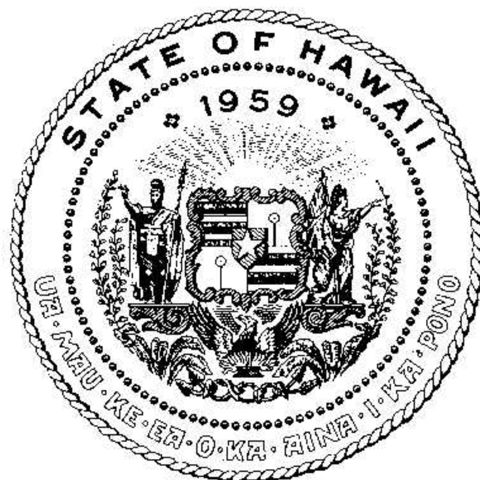
Hawaii PMMIS

Hawaii Prepaid Medical Management Information System

Technical Guide
Encounters



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1 Preface

1.1 Overview

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

1.2 Definitions

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

Term	Definition
241	Encounter Input Detail Report. This report lists encounters pended during the encounter processing cycle.
277CA	Claims Acknowledgement File. This file is generated for every 837 health plans submit.
277U	The 277U Status File includes all finalized encounter records, as well as all pended encounter records, following adjudication processing.
824	Acknowledgement file for HIPAA level 3-7 errors
834	Daily file MQD generates for each health plan listing active MQD recipients enrolled in that health plan
999	Acknowledgement file for HIPAA level 1-2 errors
Adjudicated Claim	A claim that has been received and processed by the health plan which resulted in a payment or denial of the claim.
CIS	Community Integration Services; a MQD program designed to provide supportive housing services to individuals experiencing homelessness
CMS	Centers for Medicare and Medicaid Services which as oversight responsibilities for the MQD program, including encounter reporting

Clean Claims	A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity
CRN	Claims Reference Number; A unique 15-digit number assigned to each encounter record by MQD for tracking purposes. The first five numbers of the CRN contain the Julian date, which reflects the date of receipt for adjudication processing
Copayment	A monetary amount the member pays directly to a Health Plan at the time covered services are rendered
Cost Avoidance	The process of identifying and utilizing all sources of first or third-party benefits before services are rendered by the health plan or before payment is made by the health plan
Covered services	The health and medical services to be delivered by the health plan as described in Section 4 of the QI & CCS RFPs
Denials Report	The Denials Report is generated each encounter processing cycle and lists all encounters that deny
Dual Eligible	A member who is eligible for both Medicare and Medicaid
DHS	The State of Hawai'i Department of Human Services
Encounter	A record of a medically related service rendered by a registered MQD provider to a MQD member enrolled with a health plan on the date of service. An encounter is further defined as an inpatient or outpatient claim; or each service line on a professional (HCFA 1500) or pharmacy (NCPDP) claim
Encounter Adjudication Edits and Audits	MQD adjudication system for evaluating submitted encounter data for data quality problems and duplicate records

<table>
<tr><td>Encounter Form Type</td><td>The three encounter types are:
Professional services reported with an 837P (Form A/1500)
Pharmacy services reported with a NCPDP transaction (Form C)
Institutional services reported with an 837I (Form B/UB-04). Institutional encounters are further subdivided into three additional form types: Form Type I for inpatient hospital services; Form Type O for outpatient hospital services; and Form Type L for long-term care facility services.</td></tr>
<tr><td>Encounter Manual</td><td>Reference guide for health plans that are required to submit encounter data to MQD</td></tr>
<tr><td>HAWI</td><td>Hawaii Automated Welfare Information System</td></tr>
<tr><td>HCFA</td><td>Health Care Financing Administration</td></tr>
<tr><td>Health Plan</td><td>Health plans include medical and behavioral health plans contracted with the State of Hawaii to provide services to eligible members</td></tr>
<tr><td>HIPAA</td><td>Health Insurance Portability and Accountability Act</td></tr>
<tr><td>HPMMIS</td><td>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</td></tr>
<tr><td>MQD</td><td>MQD is the Med-QUEST Division of the Hawaii Department of Human Services</td></tr>
<tr><td>PMR</td><td>Provider Master Registry; the monthly file MQD generates to inform the health plans of all providers known to MQD and their enrollment status</td></tr>
<tr><td>Provider</td><td>Any licensed or certified person or public or private institution, agency, or business concern authorized by DHS to provide healthcare, services, or supplies to MQD members</td></tr>
<tr><td>Reference Files</td><td>Files produced by MQD for health plans with information regarding service coverage</td></tr>
<tr><td>SFTP</td><td>Secure File Transfer Protocol (also known as SFTS – Secure File Transfer Server or EFT – Electronic File Transfer)</td></tr>
</table>

Subcontract	Any written agreement between the Health Plan and another party to fulfill the requirements of the health plan Contract.
Subcontractor	A party with whom the Health Plan contracts to provide services and/or conduct activities related to fulfilling the requirements of the health plan Contract.
TPL	Third Party Liability
TSN	Transmission Submitter Number; a number assigned by MQD for each submitter of encounter data. Health Plans must have one TSN and may have multiple TSNs.
Transaction Insight (TI) Encounter Validation /Translation Process	The MQD front-end editor validates syntax, code sets, and code relationships. Records that successfully pass validation are translated into file formats to be processed by the adjudication system.
VPN	Virtual Private Network

2 Encounter Reporting Overview

2.1 Encounter Definition

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

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

Encounters include, but are not limited to, the following items:

Medical Services

- Inpatient hospital services
- Outpatient hospital services
- Physician and other practitioner services
- Pharmaceutical services
- Preventive care
- Diagnostic services
- Durable medical equipment items
- Home health services
- Transportation services
- Behavioral health services

Behavioral Services

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

Health plans are responsible for reporting all encounters, including those listed below.

- Over-allowance services
- Excluded services
- Out-of-service area services
- Out-of-plan services
- Individual services reimbursed FFS under global fees and similar reimbursement schemes
- Actual service codes, even if down-coded for settlement purposes

2.2 Encounter Reporting Requirements

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

- Paid
- Health plan denials for administrative reasons
- Zero Medicaid payment due to full reimbursement by another payer or bundling of services

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

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

2.3 Use of Encounter Data

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

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

2.4 Encounter Data General Requirements

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

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

2.5 Encounter Data Certification

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

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

The BBA encounter attestation process for:

X12 (837) files

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

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

*PER*EM*TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFI*
*LEISACCURATECOMPLETEANDTRUE.CERTIFIER@PLAN.COM*FX*602 5556789*TE*6025555678~*
Where:
PER01 = IC - Information Contact
PER03 = EM - Electronic Mail.
PER04 = the attestation followed by the email address of the person who certifies the file, which must be compliant with BBA specifications
PER05 = FX - Fax Number
PER06 = The Fax Number of the person certifying the file
PER07 = TE - Telephone Number
PER08 = Telephone Number of the person certifying the file

NCPDP files

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

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

3 Encounter Processing

3.1 Encounter Data

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

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

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

3.2 Encounter Data Submission

A health plan can submit its encounter information electronically to the MQD on a daily basis, however all encounter files will be processed bi-monthly in HPMMIS on the 1st and 3rd Wednesday of each month.

All encounter files must be submitted no later than 5:00 p.m. HST on the Tuesday prior to a processing Wednesday. The encounter information must be submitted via the SFTP process described in section 3.6 Appendix 6.6 – Med-QUEST/Health Plans File Transfers.

3.3 Preparing Data for Submission

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

3.3.1 Institutional (837I)

The inpatient encounter should be used to report facility services such as inpatient hospital and institutional services. A maximum of 999 detail lines can be submitted for each encounter of this record type. Inpatient

services that are usually reported on UB-92 claim forms or other institutional claim forms are to be reported in the 837 Institutional (837I) encounter file.

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

Do not use this record type for inpatient physician visits or other professional services. Services provided by professional and technical medical providers, hospital-affiliated clinic providers, or persons normally reporting services by an HCFA-1500 claim form are to be reported in the 837 Professional encounter file.

3.3.1.1 Interim Inpatient Stays

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

3.3.1.2 Separate Admissions

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

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

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

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

3.3.1.3 Diagnosis Related Groups (DRG)

Section to be updated

3.3.2 Reporting Outpatient Encounters

Outpatient encounter record should be used to report medical-facility-based outpatient services, such as hospital emergency room, DME, Hospice, Home Health, diagnostic services provided by facilities, and dialysis services. Outpatient services that are usually reported on UB-92 claim forms or other institutional claim forms are to be reported in the 837 Institutional (837I) encounter file.

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

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

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

3.3.3 Reporting Pharmacy Encounters

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

3.3.4 Reporting Professional Encounters

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

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

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

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

3.3.5 Reporting Health Plan Administrative Denied Encounters

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

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

3.3.6 Reporting Mixed Paid/Denied Encounter Lines

When an encounter contains both paid and denied lines, they must be reported in a different manner. For Professional encounters, the denied and paid lines must be separated and reported in separate Paid and Denied (.DENY) files. To link the separated encounter, the same Patient Account Number (PAN), used in 2300/CLM01, can be submitted in both files.

For Institutional encounters, the lines do not need to be separated. Instead, the Health Plan Paid Amount would be reported as zero and the CAS segment, which would report the non-covered charge, would use CARC 96 (Non-covered charge(s)).

3.3.7 Reporting Health Plan Delivered Services

The Health Plan shall create claims and submit encounter records for direct services rendered to beneficiaries by Health Plan personnel that may otherwise be delegable to providers in the community. Examples of such services include care coordination, service coordination, housing coordination, case management, outreach efforts, medication reconciliation, and quality improvement activities. These costs shall be captured by the Health Plan as part of its general ledger.

3.4 Encounter Data Processing

Encounter data reporting for medical services provided to eligible members are submitted electronically by health plans to HPMMIS using the HIPAA 837 file format. These encounters are first edited by our Validator utilizing the HIPAA rules.

A 277CA (Claims Acknowledgement) file will be generated for every 837 file and will contain all encounters from that file with an Accepted or Rejected status. Encounters that are accepted (pass validation) will continue into our mainframe staging database and be placed in a Wait status for the next encounter cycle.

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

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

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

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

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

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

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

3.5 Encounter Record Submission Requirements

Health Plans shall follow the encounter data submission requirements described in the QI Contract Section 6.4. All encounters are expected to be received accurately and in the proper format.

The following sections present proper data submission requirements.

3.5.1 Monthly Processing Cycle

Encounter processing occurs during the 1st and 3rd Wednesdays of the month. In order for encounters to be included in the cycle, all encounter submissions must be submitted no later than 5:00 p.m. HST on the Tuesday prior to a processing Wednesday. DHS has the right to change the encounter-reporting deadline with 60 days advance notification to the health plans.

3.5.2 Media for Encounter Submissions

DHS requires health plans to submit encounter data electronically using the SFTP standard over a secure Internet connection. Refer to section 3.6 Appendix 6.6 – Med-QUEST/Health Plans File Transfers for information on the FTP process. The use of any other method is not acceptable.

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

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

3.5.3 Full Edit/Audit Processing

Encounter submissions that pass the Validation process are accepted and loaded into the HPMMIS database. Accepted submissions are processed through the full range of edits/audits during the encounter processing cycle. Effective with the 7/1/2020 cycle, current pended encounters will automatically be reprocessed through the full range of edits/audits as well.
All processed encounters will appear in the 277U file from the current encounter cycle. Refer to the 277U Companion Guide for more information on this file.

During the encounter cycle, all encounters that pass the editing/auditing process will be accepted as adjudicated or approved encounters. All other encounters that have not passed the edits/audits processing will be committed to the database as pended. Pended encounters will be reported to the health plans via the .241 Encounter Input Detail Report, for correction and resubmission. The record layout for the .241 file is located in Appendix 6.1.

Note: Effective 7/1/2020, pended encounters > 3 years from current processing day will automatically be placed in history and will no longer appear in the .241 file.

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

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

3.5.4 Duplicates

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

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

3.5.4.1 Pharmacy

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

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

3.5.4.2 UB92 Specific

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

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

3.5.4.3 Professional

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

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

3.6 Penalties

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

In accordance with the QI Contract, the State may impose financial penalties or sanctions on the plans for inaccurate, incomplete, and late submissions of required data, information, and reports.

3.6.1 Submitting Timely Data

Health Plans shall adhere to the requirements set forth in QI Contract Section 6.4 for submitting timely data.

MQD will assess timeliness of encounter data submission by each health plan during routine reconciliation as described in the Health Plan Manual Part III – Reporting Guide. Penalties for not meeting the timeliness requirements are listed in the request for proposal contract.

3.6.2 Submitting Accurate Data

Health Plans shall adhere to the requirements set forth in QI Contract Section 6.4 for submitting accurate data.

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

3.6.3 Submitting Complete Data

Health Plans shall adhere to the requirements set forth in QI Contract Section 6.4 for submitting complete data.

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

The health plan will be notified within 5-9 business days from the receipt date of the initial encounter submission of all encounters that have failed the accuracy and completeness edits. Health Plans shall review encounters that have failed these edits and take the steps necessary to correct and resubmit these encounters. Health Plans shall ensure the variance between the encounters submitted and accepted into HPMMIS and the Health Plan's claim system remains below the threshold set in the Health Plan Manual Part III – Reporting Guide.

4 Provider and Reference Files

This Section to be updated

5 How to…

This Section to be updated

6 Appendices

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

6.1 Encounter Error Report

6.1.1 File Header Record Format (Encounter Error Report 241)

Item Number	Data Element Name	Size	Type	Description
1	Health Plan	6	AN	Health Plan ID
2	Current Date	8	N	CCYYMMDD
3	File Type Code	2	AN	EN = Encounter

6.1.2 QUEST Encounter Input Error Detail Report (EN000241)

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

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

6.1.3 File Trailer Record Format (Encounter Error Report 241)

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

6.2 Encounter Reporting

3.2.1 Duplicate CRN by Error Code Report (EC97R179)

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

```
 1REPORT ID: EC97R179-Health Plan ID            HAWAII DHS MED-QUEST DIVISION HPMMIS                                        PAGE:      1
 PROGRAM #: EC97L179                               DUPLICATE CRN BY ERROR CODE                                             RUN:06/21/12
                                                         AS OF 06/21/12                                                           13:20
                                                          (ENCOUNTERS)
0TAPE SUPPLIER ID: 99                                                             2ND LINE: IN-PROCESS DATA / 3RD LINE: HISTORICAL DATA
   HEALTH PLAN ID: HP ID                                                          *****************************************************
0ERROR CODE AND MESSAGE
 ---------------------------------------------------------------------------
           CRN            HP CLAIM NUMBER                PATIENT ACCOUNT NO   HP ID  BEGIN DATE  END DATE  F PROVIDER     HAWI ID
           -------------- ------------------------------ -------------------- ------ ---------- ---------- - ---------- ---------
 Z720  EXACT DUPLICATE FOUND
           999999999999001 12345678                      12345678             HP ID  02/13/2012 02/13/2012 A 1234567890 000123456
           888888888888002 12345678                      12345678                    02/13/2012 02/13/2012 A 1234567890 000123456
- ************* END OF REPORT *************
```

6.2.2 QUEST Hawaii Cycle Encounter Report (ECHAR947)

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

REPORT ID: ECHAR947 HAWAII CYCLE ENCOUNTER REPORT PAGE: 1
PROGRAM #: ECHAL947 RUN:02/07/2003
AS OF 02/07/2003 18:06
HEALTH PLAN ID: ANY HEALTH PLAN ANYHEALTHPLAN - MEDICAL

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

Adjudicated Encounters	New encounters which were processed according to the policies and procedures of MQD and were determined to be valid.
Pended Encounters	New encounters which were processed according to the policies and procedures of MQD and did not pass the edits and audits processing.
HP Denied & Adjudicated	New encounters that were submitted in the .DENY file and were determined to be valid according to the policies and procedures of MQD.
HP Voided & Adjudicated	Encounters that were submitted with a Claim Frequency Code of '8', and were determined to be valid according to the policies and procedures of MQD.
Total Encounters Processed	Total of the Adjudicated, Pended, HP Denied & Adjudicated and HP Voided & Adjudicated encounters.
**CM Total	Cumulative total of encounters processed over a specified period

6.6 Med-QUEST/Health Plans File Transfers

6.6.1 Overview

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

6.6.2 Availability

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

6.6.3 Logon

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

6.6.4 Health Plan Filenames

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

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

6.6.5 Encounter Filenames

Files will be sent and received by health plans using the naming conventions listed in the table below. Filenames for the 837 submissions will be 20.3 where the first two characters identify the health plan; characters 3-10 the date the file was generated; characters 11-19 the Interchange Control Number found in segment ISA13 (9 digits long, needs to be zero-filled); character 20 is the form type (P or I).

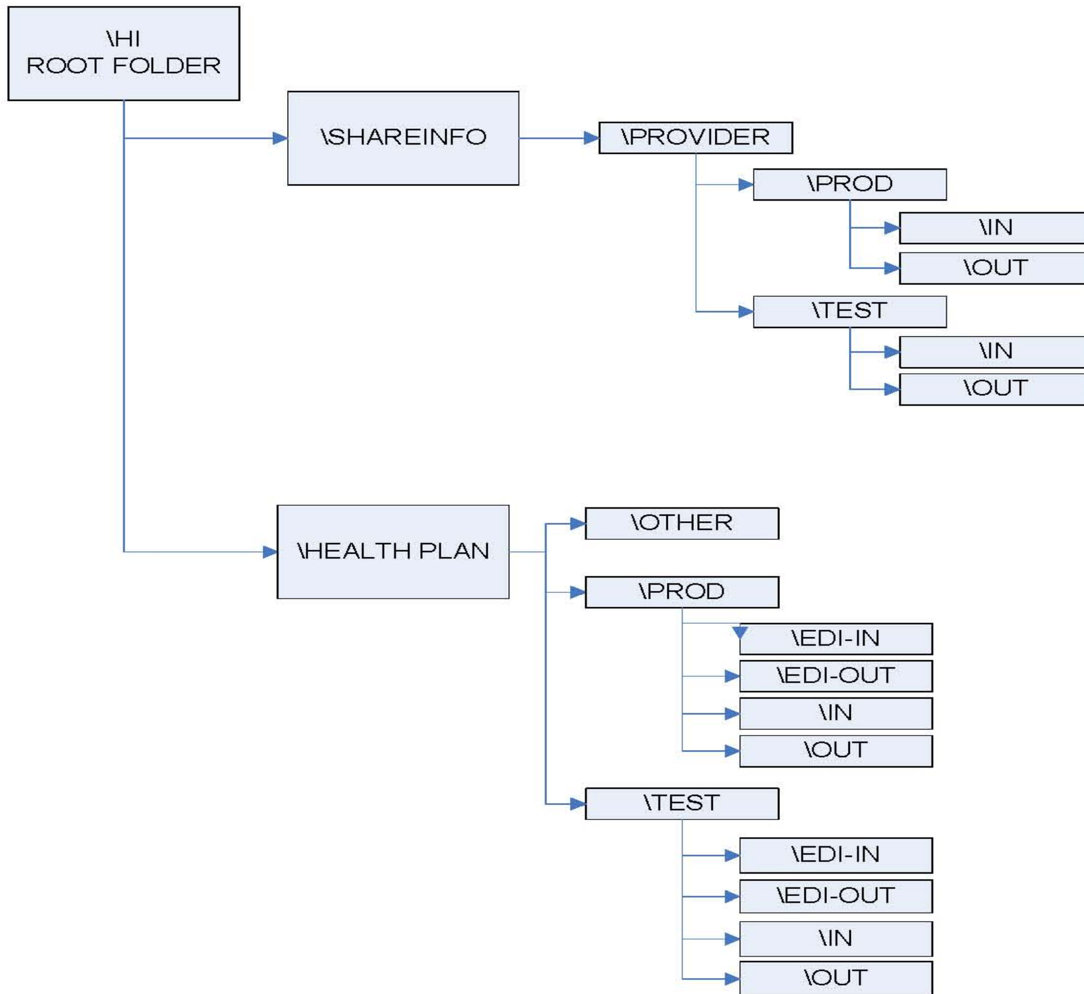
Filename for the NCPDP submission will be 16.3 where the first two characters identify the health plan; characters 3-7 will be 'NCPDP'; characters 8-15 will be the date the file was generated; character 16 will be an alpha beginning with A and incrementing to Z if there are multiple NCPDP file submissions for the same date.

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

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

6.6.6 Directory Structure

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



6.6.7 Prod Folder

Data files placed/retrieved from the sub folders under the PROD folder will be processed by HPMMIS and should be processed by the health plans to meet their contractual obligations. Encounter production files should be placed in the EDI-IN subfolder. Encounter 837 response files from our Validator as well as the 277U file will be placed in the EDI-OUT subfolder. The encounter proprietary output files and reports will be placed in the OUT subfolder.

6.6.8 Test Folder

The Test folder will be used for testing changes that the MQD or health plan may need. Encounter test files should be placed in the EDI-IN subfolder. Encounter 837 response files will be placed in the EDI-OUT subfolder. The .241, .947 and .179 files will be placed in the OUT subfolder.

The encounter test cycle runs every Thursday evening. Please submit your test files by 4:30 pm HST on Thursday at the latest. If you want to have your test files processed on another day, please submit your files by 11:30 am HST on that day and email the Systems Office to request that a special encounter test cycle be run.

There may be times when the encounter cycle will temporarily need to be run several times a week due to a special implementation project. The Systems Office will then notify the health plans of the timeframe of these special cycles.

6.6.9 Other Folder

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

6.6.10 Share Info Folder

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

6.7 Health Plan IDs

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

6.8 Health Plan TSN (Tape Supplier Number)

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

6.9 Systems Office

System	Primary
All Systems	MQD Help Desk 808-692-7952
Encounter	Wileen Ortega 808-692-7990
Provider	Wileen Ortega 808-692-7990
Health Plan & Rosters Questions	Haidee Shaw 808-692-7963
VPN, Connectivity to MQD FTP, Logons	Network Support 808-692-7952

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

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

If you have any questions, please call the 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).

7 Addendums to Health Plan Manual – Encounter

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