STATE OF HAWAII

DEPARTMENT OF HUMAN SERVICES

MED-QUEST DIVISION

**Companion Guide
and
Transaction Specifications
for the HIPAA
834 Enrollment Transaction
and
820 Capitation Transaction**

Version 2.0

March 2010

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1   Introduction

Companion Documents Companion Documents are intended to supplement the standard HIPAA Implementation Guides and are technical in nature. They are intended for technical staff members who are responsible for electronic transaction/file exchanges. This document provides specific information related to the fields and values reported in the Med-QUEST 834 and 820 transactions.

Disclaimer This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between Med-QUEST and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

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 the document, please notify the Med-QUEST Systems Office immediately.

2   834 Enrollment and 820 Capitation Transactions

2.1   Transaction Overviews

Enrollment and Capitation Transactions

834 Enrollment Transaction

Med-QUEST creates an 834 Enrollment Transaction to transfer enrollment information from the sponsor of the insurance coverage, benefits or policy (Med-QUEST) to a health care payer (a Med-QUEST or QExA health plan).

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 on subsequent changes in 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.

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.

For QExA plans, the Monthly 834 Transaction incorporates monthly Spenddown/Share of Cost data for the current and prior months.

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 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 on the 834 Enrollment Transaction. This association makes it possible for receivers of both 820 and 834 Transactions to audit payments at the member level.

2.2   834 Enrollment Transaction

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 for
- 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, TPL coverage or Spenddown/Share of Cost.

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
- Identify the current month's Spenddown/Share of Cost
- Obtain cumulative Spenddown/Share of Cost for every month that a recipient has Spenddown/Share of Cost (limited to a maximum of the last 6 months)

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 payment lines in the 820 Capitation Payment Transaction and can be used to link enrollments to member level capitation payments.

2.3 820 Capitation Transaction

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 Rosters, Monthly Rosters, and Mass Adjustment runs. Settlements, financial sanctions and other payments to and recoupments from health plans that are not member specific can also be carried 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 (derived from Voucher Numbers generated in HPMMIS) for each monthly payment. Check Numbers are available to the 820 creation process by manual entry 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

3 Technical Infrastructure and Procedures

3.1 Technical Environment

Trading Partner Setup

Trading partners receive 834 and 820 Transactions from Med-QUEST by connecting to the Med-QUEST secured File Transfer Protocol (FTP).

Technical Assistance and Help

The Med-QUEST/Systems Office provides technical assistance related to questions about electronic claims submission or data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** Oahu: (808) 692-7953
  Neighbor Islands: (800) 882-4378
- **Hours:** 7:30 AM – 5:00 PM Hawaii Time,
  Mondays through Fridays
- **Information required for initial inquiry:**
  - Customer Name
  - Organization Name
  - Customer Email Address
  - Customer Telephone Number
  - Health Plan ID/Provider ID/Submitter ID
  - Transaction ID Inquiring About
  - Applicable ISA/GS Control Numbers
  - Topic/Nature of Problem (setup, connectivity, etc.)
- **Information required for a follow up inquiry:**
  - Ticket Number assigned

3.2   Directory and File Naming Conventions

FTP Directory Naming Convention

The current structure on the FTP server is designed to provide logical access to all files, ease troubleshooting searches, and simplify security for account set ups and maintenance. Current FTP Directory file naming conventions are as follows:

FTP\HPN\(PROD\TEST)EDI-IN\EDI-OUT\IN\OUT

- HPN – The alpha numeric Health Plan Name assigned by Med-QUEST
- PROD – The default directory name indicating it is the production environment
- TEST– The default directory name indicating it is the test environment
- EDI-IN – The folder where the Health Plans upload their electronic HIPAA EDI files to Med-QUEST
- EDI-OUT – The folder where the Health Plans download their electronic HIPAA EDI files from Med-QUEST
- IN – The folder where the Health Plans uploads their electronic files to Med-QUEST
- OUT – The folder where the Health Plans downloads their electronic files from Med-QUEST

File Naming Conventions

834 Enrollment Transaction

Monthly 834 Transaction

The Monthly 834 Transaction identifies all active members of a health plan on a given date and are generated in association with monthly capitation pre-payments.

HIM834-aaaaaa-YYMMDD.TXT

- HI is the state code
- M is for Monthly
- 834 is the transaction code
- aaaaaa is the Health Plan ID
- YYMMDD is the process date
- TXT is the file extension

Daily 834 Transaction

The Daily 834 Transaction provides data on both an individual's initial enrollment and on subsequent changes in enrollment.

HID834-aaaaaa-YYMMDD.TXT

- HI is the state code
- D is for Daily
- 834 is the transaction code
- aaaaaa is the Health Plan ID
- YYMMDD is the process date
- TXT is the file extension

820 Capitation Transaction

The 820 Capitation Transaction is a monthly file that provides each Med-QUEST health plan with an electronic remittance advice for its capitation payments.

HIW820-AAAAAA-YYMMDD.TXT

- HI is the state code
- W is for Weekly (On Request)
- 820 is the transaction code
- aaaaaa is the Health Plan ID
- YYMMDD is the process date
- TXT is the file extension

Transmission   **834 Enrollment Transaction**
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 available to the health plan on the Med-QUEST secured FTP Server based on the following schedule:

Available: Each morning
Available for: 90 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 available to the health plan on the Med-QUEST secured FTP Server based on the following schedule:

Available: The morning of the first day of the month.
Available for: 90 days from the date of processing or until the next
                    Monthly Roster is generated.

820 Capitation Transaction

The 820 Capitation Transaction File is produced monthly and is available to each health plan on the Med-QUEST secured FTP Server based on the following schedule:

Available at :   On the morning following the day that the monthly
                    capitation payments are issued.
Available for: 90 days from the date of processing.

Med-QUEST sends a single 820 transaction file to each health plan every month that includes pre-payments for the current month's capitation as well as daily capitation payments and adjustments accumulated during the previous month.

4   Transaction Specifications

4.1   General Information

Overview   834 Transactions
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 will be able to understand and process the
data they receive from Med-QUEST.

820 Transactions
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 will be 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.

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).
Several entities receive 820s without 834s. In these situations, the 820
Transactions serve as payment rosters for eligible recipients.

Code Sets   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 will automatically limit 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.

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 on the Monthly Invoice Report (xxCCYYMM.CAP).

  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 will also make 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, Monthly, or Mass Adjustment Roster 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, in addition to changes in transaction format, is that health plans will receive capitation payment data once a month rather than on a daily basis.

Transaction Specifications Table

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. The outer envelopes (ISA/IEA and GS/GE segments) do not have loops and are always labeled "NA".

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/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.

4.2   834 Enrollment Transaction Specifications

Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Values	Definition/Format
ISA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
**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

				ISA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS		
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM 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

				ISA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS		
Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Values	Definition/Format
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"); however, due to the larger size of monthly transactions, the Segment Delimiter differs for the monthly file - CR/LF (carriage return/line feed – hexadecimal value X"0D0A") 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.

Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Value	Definition/Format
**GS FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS**
**GS FUNCTIONAL GROUP HEADER**
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	BE	Benefit Enrollment and Maintenance (834)
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.
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
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.
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
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		834 Transaction: 004010X095A1 Med-QUEST uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.

					834 ENROLLMENT TRANSACTION SPECIFICATIONS	
Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
Transaction Set Header						
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	834	Transaction Set Number
N/A	ST	ST02	Transaction Set Control Number	The unique identification number for a transaction set		A Transaction Number assigned by Med-QUEST. It must match the number in SE02 at the end of the transaction.
Beginning Segment						
N/A	BGN	BGN01	Transaction Set Purpose Code	Code identifying purpose of transaction set	00	Original Transmission Med-QUEST normally populates this element with "00". Values on resubmissions are coordinated with trading partners.
N/A	BGN	BGN02	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set		Med-QUEST assigns a unique Transaction Number to each 834 Transaction.
N/A	BGN	BGN03	Transaction Set Creation Date	Identifies the date the submitter created the transaction		CCYYMMDD format
N/A	BGN	BGN04	Transaction Set Creation Time	Time file is created for transmission		Time expressed in HHMM format. This is the time at which the 834 Transaction is created.
N/A	BGN	BGN05	Time Zone Code	Code identifying the time zone used in specifying a time	MS	Mountain Standard Time
N/A	BGN	BGN06	Transaction Set 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, or an "empty file where there is no activity for this daily file). Med-QUEST generates both kinds of transactions.
Transaction Set Policy Number						

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
**834 ENROLLMENT TRANSACTION SPECIFICATIONS**
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
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	Mutually Defined
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
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	Code designating the system/method of code structure used for Identification Code	FI	Federal Tax ID Number

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
1000B	N1	N104	Insurer Identification Code	Code identifying the insurer providing coverage		Health Plan Federal Tax ID
Member Level Detail						
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 Med-QUEST Action Codes used on each 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. Med-QUEST carries an HPMMIS Action in the Insurance Group or Policy Number REF Segment later in Loop 2000. Yes By definition, all Med-QUEST members are subscribers rather than dependents.
2000	INS	INS02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	18	Self

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
2000	INS	INS03	Maintenance Type Code	Code identifying a specific type of item maintenance		HIPAA Maintenance Type Codes are equivalent to the following pre-HIPAA Action Types from the Daily Roster File:
						Used when BGN08 = "2" (Daily Roster)
					001	Change - Action Type "C" on proprietary Daily Rosters
					021	Addition - Action Type "A" on proprietary Daily Rosters
					024	Termination - Action Type "D" on proprietary Daily Roster
						Used when BGN08 = "4" (Monthly Roster)
					030	Audit/Compare - no equivalent Med-QUEST Code
						The Maintenance Type Code in this loop describes the function of each 2000 Loop.

834 ENROLLMENT TRANSACTION SPECIFICATIONS

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
2000	INS	INS04	Maintenance Reason Code	Code identifying reason for the maintenance change		Daily Roster This critical data element is functionally equivalent to Action Code on pre-HIPAA Daily Rosters. See Appendix A, Med-QUEST Action Code Translation Table, for information on how specific HPMMIS Daily Roster Action Codes are handled. Only a single occurrence of Maintenance Reason Code is allowed per 2000 Loop. Because of the single occurrence limitation, each of the valid HPMMIS Action Code values for member changes (with three exceptions) generates a separate 2000 Loop and INS Segment. Note: Three HPMMIS Action Code values 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.
						Monthly Roster
					XN	For the Monthly Roster the Maintenance Reason Code to be used is XN. Notification Only To be used in complete enrollment transmissions.
2000	INS	INS05	Benefit Status Code	The type of coverage under which benefits are paid	A	Active
2000	INS	INS06	Medicare Plan Code	Code identifying the Medicare Plan	 A B C E	Current Med-QUEST Values Medicare Coverage A = Y and Medicare Coverage B = N Medicare Coverage A = N and Medicare Coverage B = Y Medicare Coverage A = Y and Medicare Coverage B = Y Medicare Coverage A = N and Medicare Coverage B = N

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
**834 ENROLLMENT TRANSACTION SPECIFICATIONS**						
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.
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.
2000	INS	INS12	Insured Individual Death Date	Date of death for subscriber or dependent		Date expressed in CCYYMMDD format. Date of Death. This field is only populated on the Daily Roster 834 if BGN08 = "2" (Daily Update Transaction).
Subscriber Number						
2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	0F	Subscriber Number
2000	REF	REF02	Subscriber Identifier	Insured's or subscriber's unique identification number assigned by a payer		HAWI/Med-QUEST ID for member
Member Policy Number						
2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1L	Group or Policy Number

					834 ENROLLMENT TRANSACTION SPECIFICATIONS
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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". All fields in the string have a fixed length. Fields prior to the final field are replaced by spaces if not present.

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 the Daily 834, Med-QUEST will pass "FYI DATA" in this element for information on the Nursing Home, Nursing Home Dates, Nursing Home Tracking Dates, Level of Care or Level of Care dates.

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. |
| Member Identification Number | | | | | | |

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
				834 ENROLLMENT TRANSACTION SPECIFICATIONS		
2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	DX 3H 17 F6 ZZ	Department/Agency Number Case Number Client Reporting Category Health Insurance Claim (HIC) Number (aka Medicare Claim ID Number) Mutually Defined This REF Segment can occur up to five times on Med-QUEST 834s: ▪ When "DX" is present, REF02 is the eligibility worker's Section (X[1]), Unit (X[2]), and Worker (X[2]) Numbers. All fields in the string have a fixed length. Fields prior to the final field are replaced by spaces if not present. ▪ When "3H" is present, REF02 is the member's Case Number (X[8]) and Relationship Code (X[2]). ▪ When "17" is present, REF02 carries the Voucher Number of the payment generated by the enrollment action when the enrollment action generates a payment. ▪ When "F6" is present, REF02 carries the member's Medicare Claim Number (X[12]). ▪ When "ZZ" is present, REF02 is the member's <u>Primary</u> HAWI/Med-QUEST ID when another ID was previously assigned and appeared on a prior Daily 834. "ZZ" is only used on enrollment terminations to be followed by corrected enrollments under the Primary ID.
2000	REF	REF02	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber		On each of the up to five REF Segments: • The eligibility worker's Section, Unit, and Worker Numbers or • The client's Case ID and Relationship Code or • The Voucher Number for the payment or • The client's Medicare Claim Identification Number or • The client's Primary Med-QUEST ID when a different ID is being terminated.
Member Level Dates						

					834 ENROLLMENT TRANSACTION SPECIFICATIONS
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 Updates, including all member Adds, that do <u>not</u> involve Island or Rate Code changes, the date in this segment 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 for 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 and Contract Type combination.
2000	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	
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.
Member Name						

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
				834 ENROLLMENT TRANSACTION SPECIFICATIONS		
2100A	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	74	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.
					IL	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.
2100A	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
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
2100A	NM1	NM104	Subscriber First Name	The first name of the insured individual or subscriber to the coverage		Med-QUEST member's first name
2100A	NM1	NM105	Subscriber Middle Name	The middle name of the subscriber to the indicated coverage or policy		Med-QUEST member's middle initial
Member Communications Numbers						
2100A	PER	PER01	Contact Function Code	Code identifying the major duty or responsibility of the person or group named	IP	Insured Person. Populated when a member's telephone number is available.
2100A	PER	PER03	Communication Number Qualifier	Code identifying the type of communication number	TE	Telephone. Populated when a member's telephone number is available.

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
**834 ENROLLMENT TRANSACTION SPECIFICATIONS**
2100A	PER	PER04	Communication Number	Complete communications number including country or area code when applicable		Telephone number supplied by client.
Member Residence Street Address
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.
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.
Member Residence City, State, Zip
2100A	N4	N401	Subscriber City Name	The City Name of the insured individual or subscriber to the coverage		Member's residence city.
2100A	N4	N402	Subscriber State Code	The State Postal Code of the insured individual or subscriber to the coverage		Member's residence state.
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).
2100A	N4	N405	Location Qualifier	Code identifying type of location	CY	County/Parish

**834 ENROLLMENT TRANSACTION SPECIFICATIONS**
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	N4	N406	Location Identification Code	Code which identifies a specific location		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.
Member Demographics
2100A	DMG	DMG01	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	
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.
2100A	DMG	DMG03	Gender Code	A code indicating the gender of the patient or insured	F M	Female Male

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
2100A	DMG	DMG05	Race or Ethnicity Code	Code indicating the racial or ethnic background of a person		HIPAA Race or Ethnicity Codes are equivalent to the following pre-HIPAA Medicare Codes from the Daily and Monthly Roster Files:
					7	UN (Unknown/Unspecified)
					A	CH (Chinese)
					A	FI (Filipino)
					A	JA (Japanese)
					A	KO (Korean)
					A	OA (Other Asians)
					E	MI (Mixed
					E	OT (Other – include HAWI value of "UN")
					H	HI (Hispanic)
					H	PR (Puerto Rican)
					I	AI (American Indian/Alaskan Native
					J	HA (Hawaiian Native)
					N	BL (Black not of Hispanic origin)
					O	WH (White not of Hispanic origin)
					P	OP (Other Pacific Islanders)
					P	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.
Member Language						
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.

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
				834 ENROLLMENT TRANSACTION SPECIFICATIONS		
2100A	LUI	LUI02	Language Code	Code indicating the language spoken by an individual		HIPAA compliant ISO 639-2 Language Codes are equivalent to the following pre-HIPAA Medicare Codes from the Daily and Monthly Roster Files:
					CHI	C (Chinese, Cantonese)
					ZHO	M (Chinese, Mandarin)
					ENG	E (English)
					HAW	H (Hawaiian)
					ILO	I (Filipino, Ilocano)
					JPN	J (Japanese)
					KMH	B (Cambodian)
					KOR	K (Korean)
					LAO	L (Laotian)
					PHI	F (Filipino, Other)
					SGN	D (Sign Language)
					SMO	N (Samoan)
					SPA	S (Spanish)
					TGL	G (Filipino, Tagalog)
					TON	T (Tongan)
					UND	P (South Pacific [other])
					UND	O (Other)
					VIE	V (Vietnamese)
Incorect Member Name						

					834 ENROLLMENT TRANSACTION SPECIFICATIONS	
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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.
2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
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.
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.

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
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.
Incorrect Member Demographics						
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.
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.
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.
Member Mailing Address						
2100C	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	31	Member's Postal Mailing Address
2100C	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
Member Mail Street Address						
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.

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
**834 ENROLLMENT TRANSACTION SPECIFICATIONS**
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.
Member City, State, Zip
2100C	N4	N401	Subscriber City Name	The City Name of the insured individual or subscriber to the coverage		Member's mailing city.
2100C	N4	N402	Subscriber State Code	The State Postal Code of the insured individual or subscriber to the coverage		Member's mailing state.
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).
Responsible Person
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. • If present, the Med-Payee's Name. Otherwise, default to the primary person in the case
2100G	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 Med-Payee or defaults to primary person in the case.
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 Med-Payee or defaults to primary person in the case.
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 Med-Payee or defaults to primary person in the case.
Responsible Person Street Address						
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 present. Otherwise, skip this segment.

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
**834 ENROLLMENT TRANSACTION SPECIFICATIONS**
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 present.
Responsible Person City, State, Zip
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 present. Otherwise, skip this segment.
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 present.
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 present.
Health Coverage

**834 ENROLLMENT TRANSACTION SPECIFICATIONS**
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	HD	HD01	Maintenance Type Code	Code identifying a specific type of item maintenance		HIPAA compliant Maintenance Type Codes are equivalent to the following pre-HIPAA Action Type Codes from the Daily and Monthly Roster Files. 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
Change – Change in an existing coverage for a health plan member
Addition – Addition of a new coverage for a new or existing health plan member

Used on Monthly 834s
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.

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 new enrollment, demographic, and other changes
• On daily 834s when there is any change to a member's TPL coverage. In this instance, there is no corresponding member transaction – only a TPL DATA record. |

The valid values column contains:
001
021

030

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
**834 ENROLLMENT TRANSACTION SPECIFICATIONS**						
2300	HD	HD03	Insurance Line Code	Code identifying a group of insurance products	HMO AK FAC LTC	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]] Nursing Home Facility Long Term Care This is the field that determines the kind of 2300 Loop that will follow. On Monthly 834s, an HMO loop is required for the medical health plan. The remaining 2300 HMO Loops will appear if applicable to the recipient.
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. If HD03 = LTC, HD04 will contain the literal SHARE OF COST/ SPENDDOWN, if data is present.
Health Coverage Dates						

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
**834 ENROLLMENT TRANSACTION SPECIFICATIONS**						
2300	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	303 348 349	Maintenance Effective (HPMMIS Process Date) 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).
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.
2300	DTP	DTP03	Coverage Period	The coverage period associated with this premium payment		The Enrollment Begin Date, the Enrollment End Date or the Process Date. Date expressed in format CCYYMMDD.
Health Coverage Policy						
2300	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	P3	Premium Amount
2300	AMT	AMT02	Monetary Amount	Monetary Amount		This amount can be 0 (zero). Whole dollar amounts will appear without any decimal point and cents
Health Coverage Policy Number						

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
**834 ENROLLMENT TRANSACTION SPECIFICATIONS**
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	17 ZZ	Client Reporting Category Mutually Defined To designate any Share of Cost/Spenddown data
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		For Behavioral Health Entities (when HD03=AK), then the Contract Type (X[01]) and Behavioral Health Reporting Category (X[01]) are returned. Contract Type (X[01]) is returned for all other Med-QUEST health plans/facilities. For Share of Cost /Spenddown transactions, this represents the month the Share of Cost or Spenddown amount was applied. Date expressed in format CCYYMM. An indicator of "Y" is used to identify Penalized situations.
Coordination of Benefits
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
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 fixed length HPMMIS fields are used to populate this element with its 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]) All fields in the string have a fixed length. Fields prior to the final field are replaced by spaces if not present. Sub-field lengths reflect actual data lengths. They sometimes differ from the field lengths in HPMMIS and in the pre-HIPAA Roster.

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
**834 ENROLLMENT TRANSACTION SPECIFICATIONS**
2320	COB	COB03	Coordination of Benefits Code	Code identifying whether there is a coordination of benefits	5	Unknown
Additional Coordination of Benefits Identifiers
2320	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	6P	
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])
Other Insurance Company Name
2320	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	IN	Insurer
2320	N1	N102	Insurer Name	Name of the insurer providing coverage		Descriptive Name of the TPL Carrier
Coordination of Benefits Eligibility Dates
2320	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	344 345	Begin Date for Other Insurance Coverage End Date for Other Insurance Coverage
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.
2320	DTP	DTP03	Coordination of Benefits Date	The dates of eligibility for coordination of benefits		Begin Date for Other Insurance Coverage. Used when DTP01 above is 344. or End Date for Other Insurance Coverage. Used when DTP01 above is 345. Date expressed in format CCYYMMDD

Loop ID	Segment ID	Element ID	Element Name	Element Definition	Valid Values	Definition/Format
834 ENROLLMENT TRANSACTION SPECIFICATIONS						
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.
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.

GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS							
Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Value	Definition/Format	Source
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

IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Values	Definition/Format
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.

4.3   820 Capitation Transaction Specifications

Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Values	Definition/Format
ISA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
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

ISA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Values	Definition/Format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM 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

ISA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Values	Definition/Format
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"); however, due to the larger size of monthly transactions, the Segment Delimiter differs for the monthly file - CR/LF (carriage return/line feed – hexadecimal value X"0D0A")
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. |

				GS FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS		
Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Value	Definition/Format
GS FUNCTIONAL GROUP HEADER						
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	RA	Payment Order/Remittance Advice (820)
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.
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
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMMSS format.		The functional group creation time.
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.
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
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		820 Transaction: 004010X061A1 Med-QUEST uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
**820 CAPITATION TRANSACTION SPECIFICATIONS**
820 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 will be processed	U	Split Payment and Remittance
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. |
| 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. |

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
				820 CAPITATION TRANSACTION SPECIFICATIONS		
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
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.

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
**820 CAPITATION TRANSACTION SPECIFICATIONS**
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 Number
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.
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

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
820 CAPITATION TRANSACTION SPECIFICATIONS						
1000A	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer's 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
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	Hawaii Medicaid	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	National Employer Identification
1000B	N1	N104	Premium Payer Identifier	Number identifying the organization remitting the payment		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
1000A	N3	N302	Receiver Address Line	The receiver's address line		Health Plan or Agency 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

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
**820 CAPITATION TRANSACTION SPECIFICATIONS**
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
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.
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 Detail
2300A	RMR	RMR01	Reference Identification Qualifier	Code qualifying the reference identification	IK	Invoice Number Required if the 2000A Loop is present.

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
				820 CAPITATION TRANSACTION SPECIFICATIONS		
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. In some situations, Voucher Numbers that appear on the 834 Transactions reflect zero payment amounts and have no corresponding Voucher Number on the 820.
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 will send 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 will contain 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.

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
**820 CAPITATION TRANSACTION SPECIFICATIONS**
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.
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

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
				820 CAPITATION TRANSACTION SPECIFICATIONS		
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 Rosters) and adjustments (Daily Rosters and Mass Adjustment Rosters). 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
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
2100B	NM1	NM104	Individual First Name	The first name of an individual to whom specific remittance amounts apply		Member's First Name

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
820 CAPITATION TRANSACTION SPECIFICATIONS						
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
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]) All fields in the string have a fixed length. Fields prior to the final field are replaced by spaces if not present. In some situations, Voucher Numbers that appear on the 834 Transactions reflect zero payment amounts and have no corresponding Voucher Number on the 820.
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

Loop ID	Seg ID	Element ID	Element Name	Element Definition	Valid Value	Definition/Format
820 CAPITATION TRANSACTION SPECIFICATIONS						
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 Rosters, the coverage period will be from the first to the last day of the pre-payment month. On payments from Daily Rosters and mass adjustments, the period will be the period covered by the adjustment.
820 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.

Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Value	Definition/Format	Source
GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS							
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

Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Values	Definition/Format
IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
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.

Appendix A – Med-QUEST Action Code Translation Table

Action Type	Maintenance Type Code	Action Code	Description	834 Translation/Maintenance Reason Code Value
A	021	AA	Algorithm Assigned	28 – Initial Enrollment
A	021	AI	Admin-In	28 – Initial Enrollment
A	021	BI	Enrollment Block In	28 – Initial Enrollment
A	021	CI	County Move-In	28 – Initial Enrollment
A	021	EC	Enrollment Choice	28 – Initial Enrollment
A	021	EI	Open Enrollment-In	22 – Plan Change
A	021	NB	Newborn	02 – Birth
A	021	NE	Normal Enrollment	28 – Initial Enrollment
A	021	PA	End of Contract-In - Auto Assign	22 – Plan Change
A	021	RA	Retroactive Enrollment	28 – Initial Enrollment
A	021	RE	Re-Enrollment	41 – Re-enrollment
C	001	AC	Address Change	43 – Change of location
C	001	C1	"Combination Action Code" DB, NC, SX	25 – Change in Identifying Data Element
C	001	C2	"Combination Action Code" DB, NC	25 –Change in Identifying Data Element
C	001	C3	"Combination Action Code" DB, SX	25 –Change in Identifying Data Element
C	001	C4	"Combination Action Code" NC, SX	25 –Change in Identifying Data Element
C	001	CM	Change in Medicare	33 – Personnel Data
C	001	DB	Date of Birth Change	25 –Change in Identifying Data Element
C	001	HC	Acute Health Plan Change	22 – Plan Change
C	001	MC	Mental Health Change	22 – Plan Change
C	001	NC	Name Change	25 – Change in Identifying Data Element
C	001	OC	Other Change	33 – Personnel Data
C	001	PG	Pregnant Women	21 – Disability
C	001	RC	Rate Code Change	29 – Benefit Selection
C	001	SC	Share of Cost / Spenddown Change	33 – Personnel Data
C	001	SX	Sex Change	25 – Change in Identifying Data Element
C	001	TM	Mental Health Termination	07 – Termination of Benefits
D	024	AG	Age Term	07 – Termination of Benefits
D	024	AO	Admin Out	07 – Termination of Benefits
D	024	BO	Enrollment Block Out	07 – Termination of Benefits
D	024	CG	90-Day Grace Period Disenroll	22 – Plan Change
D	024	CH	Eligibility Change - Disenroll	07 – Termination of Benefits
D	024	CO	County Move-Out	07 – Termination of Benefits
D	024	DE	Deceased	03 – Death
D	024	EO	Open Enrollment-Out	22 – Plan Change
D	024	IE	Ineligible	07 – Termination of Benefits
D	024	IN	Incarcerated/Institutionalized	07 – Termination of Benefits
D	024	OS	Out of State Move	07 – Termination of Benefits
D	024	PT	End of Contract-Out - %, AA,	22 – Plan Change
D	024	RD	Retroactive Disenrollment	07 – Termination of Benefits
D	024	VW	Voluntary Withdrawal	14 – Voluntary Withdrawal

834/820 Companion Document v2.0
Change Summary

#	Location	Previously Stated	Revision
1	Entire document	-	\<revised to eliminate redundant and dated information\>
2	p.4, § 2.1 Transaction Overviews Enrollment and Capitation Transactions section, 834 Enrollment Transaction subsection, Last paragraph	-	For QExA plans, the Monthly 834 Transaction incorporates monthly Spenddown/Share of Cost data for the current and prior months.
3	p.5, § 2.2 834 Enrollment Transaction, Purpose section 4th bullet following 2nd paragraph	• Other changes for each member such as changes in Rate Code or TPL coverage	• Other changes for each member such as changes in Rate Code, TPL coverage or Spenddown/Share of Cost
4	p.5, § 2.2 834 Enrollment Transaction, Purpose section 3rd and 4th bullets following 3rd paragraph	-	• Identify the current month's Spenddown/Share of Cost • Obtain cumulative Spenddown/Share of Cost for every month that a recipient has Spenddown/Share of Cost (limited to a maximum of the last 6 months)
5	p.7, § 3.1 Technical Environment, Trading Partner Setup section	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.	Trading partners receive 834 and 820 Transactions from Med-QUEST by connecting to the Med-QUEST secured File Transfer Protocol (FTP).

#	Location	Previously Stated	Revision
6	p.8, § 3.2 Directory and File Naming Conventions, FTP Directory Naming Convention section, 2nd paragraph and bullets that followed	FTP\HPN\(Production\Test)Rosters\(ACKIN\Daily\Monthly) • HPN – The alpha numeric Health Plan Name assigned by Med-QUES • Production – The default directory name indicating it is the production environment • Test – The default directory name indicating it is the test environment • Rosters – The default directory name indicating enrollment transactions and invoices • ACKIN – The default directory name indicating both daily and monthly acknowledgements • Daily – The default directory name indicating daily files • Monthly – The default directory name indicating monthly files	FTP\HPN\(PROD\TEST)EDI-IN\EDI-OUT\IN\OUT\ • HPN – The alpha numeric Health Plan Name assigned by Med-QUES • PROD – The default directory name indicating it is the production environment • TEST– The default directory name indicating it is the test environment • EDI-IN – The folder where the Health Plans upload their electronic HIPAA EDI files to Med-QUEST • EDI-OUT – The folder where the Health Plans download their electronic HIPAA EDI files from Med-QUEST • IN – The folder where the Health Plans uploads their electronic files to Med-QUEST • OUT – The folder where the Health Plans downloads their electronic files from Med-QUEST
7	p.9, § 3.2 Directory and File Naming Conventions, File Naming Conventions section, Monthly 834 Transaction subsection	The Monthly 834 Transaction identifies all active members of a health plan on a given date and are generated in association with monthly capitation pre-payments. Refer to Section 2, 834 Enrollment and 820 Transactions, for additional information. HPCCYYMM.MLR • HP is the Health Plan Identifier • CCYYMM is the process month. • MRL is the Monthly Reconciliation file	The Monthly 834 Transaction identifies all active members of a health plan on a given date and are generated in association with monthly capitation pre-payments. HIM834-aaaaaa-YYMMDD.TXT • HI is the state code • M is for Monthly • 834 is the transaction code • aaaaaa is the Health Plan ID • YYMMDD is the process date • TXT is the file extension
8	p.9, § 3.2 Directory and File Naming Conventions, File Naming Conventions section, Daily 834 Transaction subsection	The Daily 834 Transaction provides data on both an individual's initial enrollment and on subsequent changes in enrollment. Refer to Section 2, 834 Enrollment and 820 Transactions, for additional information. HPYYMMDD.DLR • HP is the Health Plan Identifier • YYMMDD is the process date. • DLR is the Daily Enrollment file	The Daily 834 Transaction provides data on both an individual's initial enrollment and on subsequent changes in enrollment. HID834-aaaaaa-YYMMDD.TXT • HI is the state code • D is for Daily • 834 is the transaction code • aaaaaa is the Health Plan ID • YYMMDD is the process date • TXT is the file extension

#	Location	Previously Stated	Revision
9	p.9, § 3.2 Directory and File Naming Conventions, File Naming Conventions section, 820 Capitation Transaction subsection	The 820 Capitation Transaction is a monthly file that provides each Med-QUEST health plan with an electronic remittance advice for its capitation payments. Refer to Section 2, 834 Enrollment and 820 Transactions, for additional information. HPYYMMDD.820 • HP is the Health Plan Identifier • YYMMDD is the process date • 820 is the Transaction code	The 820 Capitation Transaction is a monthly file that provides each Med-QUEST health plan with an electronic remittance advice for its capitation payments. HIW820-AAAAAA-YYMMDD.TXT • HI is the state code • W is for Weekly (On Request) • 820 is the transaction code • aaaaaa is the Health Plan ID • YYMMDD is the process date • TXT is the file extension
10	p.10, § 3.2 Directory and File Naming Conventions, Transmission Schedules section, 834 Enrollment Transaction subsection, 1st paragraph, 2nd sentence	This file is generally available to the health plan on the Med-QUEST FTP Server based on the following schedule:	This file is available to the health plan on the Med-QUEST secured FTP Server based on the following schedule:
11	p.10, § 3.2 Directory and File Naming Conventions, Transmission Schedules section, 834 Enrollment Transaction subsection, 2nd paragraph, 2nd line	Available for: 7 days from the date of processing	Available for: 90 days from the date of processing
12	p.10, § 3.2 Directory and File Naming Conventions, Transmission Schedules section, 834 Enrollment Transaction subsection, 3rd paragraph	The 834 Monthly Enrollment Transaction File containing a prospective roster of all currently active members is produced on the dlast day of each month and is generally available to the health plan on the Med-QUEST FTP Server based on the following schedule:	The 834 Monthly Enrollment Transaction File containing a prospective roster of all currently active members is produced on the dlast day of each month and is available to the health plan on the Med-QUEST secured FTP Server based on the following schedule:
13	p.10, § 3.2 Directory and File Naming Conventions, Transmission Schedules section, 834 Enrollment Transaction subsection, 4th paragraph, 2nd line	Available for: 30 days from the date of processing or until the next Monthly Roster is generated.	Available for: 90 days from the date of processing or until the next Monthly Roster is generated.

#	Location	Previously Stated	Revision
14	p.10, §3.2 Directory and File Naming Conventions, Transmission Schedules section, 834 Enrollment Transaction subsection, Last paragraph	Med-QUEST sends a single 820 transaction file to each health plan every month that includes pre-payments for the next month's capitation as well as daily capitation payments and adjustments accumulated during the previous month.	<moved to following subsection>
15	p.10, § 3.2 Directory and File Naming Conventions, Transmission Schedules section, 820 Capitation Transaction subsection, 1st paragraph	The 820 Capitation Transaction is produced monthly and is generally available to each health plan on the Med-QUEST FTP based on the following schedule:	The 820 Capitation Transaction is produced monthly and is available to each health plan on the Med-QUEST secured FTP based on the following schedule:
16	p.10, § 3.2 Directory and File Naming Conventions, Transmission Schedules section, 820 Capitation Transaction subsection, 2nd paragraph	Available at : 7:00am HST on the morning following the day that the monthly capitation payments are issued. Available for: 30 days from the date of processing.	Available at : On the morning following the day that the monthly capitation payments are issued. Available for: 90 days from the date of processing.
17	p.10, §3.2 Directory and File Naming Conventions, Transmission Schedules section, 820 Capitation Transaction subsection, Last paragraph	<moved from previous subsection>	Med-QUEST sends a single 820 transaction file to each health plan every month that includes pre-payments for the current month's capitation as well as daily capitation payments and adjustments accumulated during the previous month.
18	p.10, § 3.2 Directory and File Naming Conventions, File Naming Conventions section, TA1 Interchange Acknowledgement Transactions subsection, 1st paragraph, last sentence	Refer to Section 4.3, Acknowledgement Procedures, for additional information.	<deleted>
19	p.10, § 3.2 Directory and File Naming Conventions, File Naming Conventions section, 997 Functional Acknowledgement Transactions subsection, 1st paragraph, last sentence	Refer to Section 4.3, Acknowledgement Procedures, for additional information.	<deleted>

#	Location	Previously Stated	Revision
20	p.10, § 3.2 Directory and File Naming Conventions, File Naming Conventions section, 824 Implementation Guide Reporting Transactions subsection, 1st paragraph, last sentence	Refer to Section 4.3, Acknowledgement Procedures, for additional information.	<deleted>
21	p.11, §4.1 General Information, Overview section, 820 Transactions subsection, 1st paragraph, last sentence	The 820 Transaction represents the financial aspect of the pre-HIPAA Daily and Monthly Roster Files.	<deleted>
22	p.11, § 4.1 General Information, Overview, 820 Transactions section, last paragraph and bulleted list that follows	The following entities receive 820 Transactions from Med-QUEST: • Medical Heath Plans (AlohaCare, HMSA, Kaiser, and Summerlin) • QExA Health Plans (Evercare and Ohana) • The Department of Health for the Early Intervention [behavioral health] Program (DOH/EIP) • The Department of Health's Children's and Adolescent Mental Health Division (CAMHD) • Adult Mental Health carve-out (APS Health Care) • The Program of All Inclusive Care for the Elderly (PACE)	<deleted>
23	p.13, § 4.1 General Information, Other Standards section, 820 Capitation Transaction subsection, 2nd bullet	• 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.	• 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 on the Monthly Invoice Report (xxCCYYMM.CAP).

#	Location	Previously Stated	Revision
24	p.17, §4.2 834 Enrollment Transaction Specifications, ISA Interchange Control Envelope Transaction Specifications section, Element ISA16, Definition/Format column, 2nd paragraph	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"). **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.	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"); however, due to the larger size of monthly transactions, the Segment Delimiter differs for the monthly file - CR/LF (carriage return/line feed – hexadecimal value X"0D0A") **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.
25	p.18, § 4.2 834 Enrollment Transaction Specifications, GS Functional Group Envelope Transaction Specifications section, Element GS01, Valid Value and Definition/Format columns	BE Benefit Enrollment and Maintenance (834) RA Payment Order/Remittance Advice (820)	BE Benefit Enrollment and Maintenance
26	p.18, §4.2 834 Enrollment Transaction Specifications, GS Functional Group Envelope Transaction Specifications section, Element GS05, Element Definition/Length column	Time on a 24-hour clock in HHMMSS format.	Time on a 24-hour clock in HHMM format.
27	p.18, §4.2 834 Enrollment Transaction Specifications, GS Functional Group Envelope Transaction Specifications section, Element GS08, Definition/Format column	834 Transaction : 004010X095A1 820 Transaction : 004010X061A1	834 Transaction : 004010X095A1

#	Location	Previously Stated	Revision
28	p.19, §4.2 834 Enrollment Transaction Specifications, Element BGN08 Valid Values and Definition/Format columns	2 Change 4 Update BGN08 "4" transactions contain snapshots of all active health plan members (equivalent to the Monthly Roster).	2 Change 4 Verify BGN08 "4" transactions contain snapshots of all active health plan members (equivalent to the Monthly Roster, or an "empty file where there is no activity for this daily file).
29	p.21, §4.2 834 Enrollment Transaction Specifications, Loop 2000, Element INS01, Definition/Format column, 1st paragraph, 2nd sentence	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 pre-HIPAA HPMMIS update record.	In addition, on Daily 834s, the loop occurs (with exceptions) once for each of the Med-QUEST Action Codes used on each HPMMIS update record.
30	p.21, §4.2 834 Enrollment Transaction Specifications, Loop 2000, Element INS01, Definition/Format column, 2nd paragraph, 2nd sentence	All the same, Med-QUEST carries a pre-HIPAA, HPMMIS Action in the Insurance Group or Policy Number REF Segment later in Loop 2000.	Med-QUEST carries an HPMMIS Action in the Insurance Group or Policy Number REF Segment later in Loop 2000.
31	p.23, §4.2 834 Enrollment Transaction Specifications, Loop 2000, Element INS04, Definition/Format column, 2nd paragraph, 1st sentence	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 pre-HIPAA Daily Roster Records).	Only a single occurrence of Maintenance Reason Code is allowed per 2000 Loop.

#	Location	Previously Stated	Revision
32	p.23, §4.2 834 Enrollment Transaction Specifications, Loop 2000, Element INS04, Definition/Format column, 3rd paragraph under Daily Roster	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 o member data ("HK" and "SB") Daily Roster updates with these Action Code values do not appear n the 834 but will appear on the 820 Capitation Transaction	Note : Three HPMMIS Action Code values 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.
33	p.24, §4.2 834 Enrollment Transaction Specifications, 834 Enrollment Transaction Specifications section, Loop 2000, Element INS06 Definition/Format column, 1st paragraph	HIPAA Medicare Plan Codes are equivalent to the following pre-HIPAAA Medicare Codes from the Daily Roster File :	<deleted>
34	p.25, § 4.2 834 Enrollment Transaction Specifications, Loop 2000, Element REF02, Definition/Format column, 4th paragraph	On the Daily 834, Med-QUEST will pass "FYI DATA" in this element for changes in information to the Nursing Home, Nursing Home Dates, Nursing Home Tracing Dates, Level of Care or Level of Care dates.	On the Daily 834, Med-QUEST will pass "FYI DATA" in this element for information on the Nursing Home, Nursing Home Dates, Nursing Home Tracking Dates, Level of Care or Level of Care dates.
35	p.26, §4.2 834 Enrollment Transaction Specifications, 834 Enrollment Transaction Specifications section, Loop 2000, Element REF01, 4th paragraph of Valid Values and Definition/Format columns	-	F6 Health Insurance Claim (HIC) Number (aka Medicare Claim ID Number)

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36	p.26, §4.2 834 Enrollment Transaction Specifications, 834 Enrollment Transaction Specifications section, Loop 2000, Element REF01, Definition/Format column, 4th and 5th bullet	- • When "ZZ" is present, REF02 is the member's <u>Primary HAWI/Med-QUEST ID</u> when another ID was previously assigned and appeared on a prior Daily 834. "ZZ" is only used on enrollment terminations to be followed by corrected enrollments under the Primary ID.	• When "F6" is present, REF02 carries the member's Medicare Claim Number (X[12]). • When "ZZ" is present, REF02 is the member's <u>Primary HAWI/Med-QUEST ID</u> when another ID was previously assigned and appeared on a prior Daily 834. "ZZ" is only used on enrollment terminations to be followed by corrected enrollments under the Primary ID.
37	p.26, §4.2 834 Enrollment Transaction Specifications, 834 Enrollment Transaction Specifications section, Loop 2000, Element REF01, Paragraphs following bulleted list	- <u>2nd Segment Specific</u> If CASE-IID is not blank on 834 Input File, autoplug "3H"; If CASE-ID is blank, skip this iteration, <u>3rd Segment Specific</u> If VOUCHER-NUM is not blank on 834 Input File, autoplug "17"; If VOUCHER-NUM is blank, skip this iteration. <u>4th Segment Specific</u> If MDC-CLM-ID is not blank on the 834 Input File, autoplug "F6"; If MDC-CLM-ID is blank, skip this iteration <u>5th Segment Specific</u> If PRI-CLIENT-ID is not blank on 834 Input File, autoplug "ZZ"; If PRI-CLIENT-ID is blank, skip this iteration	<deleted>
38	p.26, §4.2 834 Enrollment Transaction Specifications, 834 Enrollment Transaction Specifications section, Loop 2000, Element REF02, Paragraphs following bulleted list	<u>2nd Segment Specific</u> If present, concatenate and 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 8 space. <u>3rd Segment Specific</u> Move VOUCHER-NUM from Input File <u>4th Segment Specific</u> Move MDC-CLM-ID from Input File <u>5th Segment Specific</u> Move PRI-CLIENT from Input File	<deleted>

#	Location	Previously Stated	Revision
39	p.27, § 4.2 834 Enrollment Transaction Specifications, Member Level Dates section, Loop 2000, Element DTP01, Definition/Format column, 2nd paragraph	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, including all member Adds, that do not involve Island or Rate Code changes, the date in this field is the Maintenance Effective Date (Qualifier value "303").	On Daily Updates, including all member Adds, that do not involve Island or Rate Code changes, the date in this segment is the Maintenance Effective Date (Qualifier value "303").
40	p.27, § 4.2 834 Enrollment Transaction Specifications, Member Level Dates section, Loop 2000, Element DTP01, Definition/Format column, last paragraph	On Monthly 834s, this segment carries the Begin Date of the most current Island/Rate Code combination.	On Monthly 834s, this segment carries the Begin Date of the most current Island, Rate Code and Contract Type combination.
41	p.28, § 4.2 834 Enrollment Transaction Specifications, Loop 2100A, Element PER01, Definition/Format column	Insured Person. Populated when a member's home telephone number is available.	IP = Insured Person. Populated when a member's telephone number is available.
42	p.29, §4.2 834 Enrollment Transaction Specifications, 834 Enrollment Transaction Specifications section, Loop 2100A, Element PER03, Valid Values and Definition/Format columns	HP	TE = Telephone. Populated when a member's telephone number is available.
43	p.29, § 4.2 834 Enrollment Transaction Specifications, Member Communications Numbers section, Loop 2100A, Element PER04, Definition/Format column	Home Telephone Number. Populated with member's home telephone number.	Telephone number supplied by client.

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44	p.35, § 4.2 834 Enrollment Transaction Specifications, Responsible Person section, Loop 2100G, Element NM101, Definition/Format column	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. Two separate responsible person entities are represented in the same 2100G Loop. Address fields are for the case worker/medical payee, not for the primary person in the case.	Responsible Person The 2100G Loop is for data that identifies "the person responsible for the member. • If present, the Med-Payee's Name. Otherwise, default to the primary person in the case
45	p.36, § 4.2 834 Enrollment Transaction Specifications, Responsible Person section, Loop 2100G, Element NM103, Definition/Format column	The last name of the primary person in the case.	The last name of the Med-Payee or defaults to primary person in the case.
46	p.36, § 4.2 834 Enrollment Transaction Specifications, Responsible Person section, Loop 2100G, Element NM104, Definition/Format column	The first name of the primary person in the case.	The first name of the Med-Payee or defaults to primary person in the case.
47	p.36, § 4.2 834 Enrollment Transaction Specifications, Responsible Person section, Loop 2100G, Element NM105, Definition/Format column	The middle initial of the primary person in the case.	The middle initial of the Med-Payee or defaults to primary person in the case.
48	p.36, § 4.2 834 Enrollment Transaction Specifications, Responsible Person Street Address section, Loop 2100G, Element N301, Definition/Format column	The first line of the "Medical Payee Address" if it is present.	The first line of the "Medical Payee Address" if present. Otherwise, skip this segment.

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49	p.37, § 4.2 834 Enrollment Transaction Specifications, Responsible Person Street Address section, Loop 2100G, Element N302, Definition/Format column	The second line of the "Medical Payee Address" if it is present.	The second line of the "Medical Payee Address" if present.
50	p.37, § 4.2 834 Enrollment Transaction Specifications, Responsible Person City, State, Zip section Loop 2100G, Element N401, Definition/Format column	The city of the "Medical Payee Address" if it is present.	The city of the "Medical Payee Address" if present. Otherwise, skip this segment.
51	p.37, § 4.2 834 Enrollment Transaction Specifications, Responsible Person City, State, Zip section, Loop 2100G, Element N402, Definition/Format column	The State Code of the "Medical Payee Address" if it is present.	The State Code of the "Medical Payee Address" if present.
52	p.37, § 4.2 834 Enrollment Transaction Specifications, Responsible Person City, State, Zip section, Loop 2100G, Element N403, Definition/Format column	The Zip Code of the "Medical Payee Address" if it is present. May be either five or nine digits	The ZIP Code of the "Medical Payee Address" if present.
53	p.38, § 4.2 834 Enrollment Transaction Specifications, Health Coverage section heading only (Loop 2300, Segment HD) following loop 2100G	-	Health Coverage
54	p.38, § 4.2 834 Enrollment Transaction Specifications, Health Coverage section, Loop 2300, Element HD01, Valid Values and Definition/Format columns	024 Termination – Ending of a coverage for an existing or terminating health plan member	<deleted>

#	Location	Previously Stated	Revision
55	p.38, § 4.2 834 Enrollment Transaction Specifications, Health Coverage subsection, Loop 2300, Element HD01, Definition/Format column, Last two bullets following the last paragraph	• On Daily 834s for newly enrolled members • On daily 834s when there is any change to a member's TPL coverage	• On Daily 834s for new enrollment, demographic, and other changes • On daily 834s when there is any change to a member's TPL coverage. In this instance, there is no corresponding member transaction – only a TPL DATA record.
56	p.39, § 4.2 834 Enrollment Transaction Specifications, Loop 2300, Element HD04, Definition/Format column	The Health Plan Name (X[25]) appears in this element. On Daily 834 re-enrollments and health plan changes, the Prior Name (x[25]) follows the name of the current plan. If HD03 = FAC or LTC, HD04 may contain the following description or literal, if data is present 1. Nursing Home code followed by a space before a description of the Nursing Home 2. Nursing Home code followed by a space before a description of the Nursing Home followed by the literal DELETED 3. The literal NURSING HOME TRACK DATE 4. The literal NURSING HOME TACK DATE DELETED 5. The literal NURSING HOME LEVEL OF CARE 6. The literal NURSING HOME LEVEL OF CARE DELETED 7. The literal NURSING HOME PENALIZED 8. The literal NURSING HOME PENALIZED DELETED 9. The literal SHARE OF COST/SPENDDOWN	The Health Plan Name (X[25]) appears in this element. On Daily 834 re-enrollments and health plan changes, the Prior Name (x[25]) follows the name of the current plan. If HD03 = LTC, HD04 will contain the literal SHARE OF COST/ SPENDDOWN, if data is present.
57	p.41, §4.2 834 Enrollment Transaction Specifications, 834 Enrollment Transaction Specifications section, Loop 2300, Element REF02, Definition/Format column, 1st paragraph	Contract Type (X[01]) and Behavioral Health Reporting Category (X[01]). Behavioral Health Reporting Category appears only for behavioral health coverages. All fields in the string have a fixed length. Fields prior to the final field are replaced by spaces if not present.	For Behavioral Health Entities (when HD03=AK), then the Contract Type (X[01]) and Behavioral Health Reporting Category (X[01]) are returned. Contract Type (X[01]) is returned for all other Med-QUEST health plans/facilities.

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58	p.41, §4.2 834 Enrollment Transaction Specifications, 834 Enrollment Transaction Specifications section, Loop 2320, Element COB02, Definition/Format column, 1st two paragraphs	Four fixed length HPMMIS fields are used to populate this element with its maximum length of 13 characters: TPL Code (X[2]) TPL Sequence Number (X[2]) **Absent Parent Indicator** (X[1]) Last Modification Date (CCYYMMDD) (X[8])	Five fixed length HPMMIS fields are used to populate this element with its 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])
59	p.42, §4.2 834 Enrollment Transaction Specifications, 834 Enrollment Transaction Specifications section, Loop 2320, DTP Segment Header only, following Element N102	-	Coordintation of Benefits Eligibility Dates
60	p.48, § 4.3 820 Capitation Transaction Specifications, GS Functional Group Header section, Element GS01, Valid Value and Definition/Format columns	BE Benefit Enrollment and Maintenance (834) RA Payment Order/Remittance Advice (820)	RA Payment Order/Remittance Advice
61	p.48, § 4.3 820 Capitation Transaction Specifications, GS Functional Group Envelope Transaction Specifications section, Element GS08, Definition/Format column	834 Transaction : 004010X095A1 820 Transaction : 004010X061A1	820 Transaction : 004010X061A1
62	p.52, § 4.3 820 Capitation Transaction Specifications, Loop 1000B, Element N102, Valid Valuecolumn	MED-QUEST	Hawaii Medicaid
63	p.60, Appendix A – Med-QUEST Action Code Translation table, New column (Maintenance Type) following Action Type Column	-	<new Maintenance Type column> 021 if the Action Type = A 001 if the Action Type = C 024 if the Action Type = D

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64	p.60, Appendix A – Med- QUEST Action Code Translation Table, Action Type C section, Action Code CM	-	\<insert new row for Action Code CM\> C 001 CM Change in Medicare 33 – Personnel Data
65	p.61, Appendix B – Med- QUEST Contract Types Table	\<entire Appendix\>	\<deleted\>