HAWAII DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION

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

VERSION 1.1
APRIL 2002

DRAFT

Revision History

Date	Version	Description	Author
3/10/2003	1.0	Initial draft for posting to the Med-QUEST	Med-QUEST Systems Office
4/30/2003	1.1	Second draft in response to Hawaii comments	Med-QUEST Systems Office

Revision Roadmap

** Page numbers refer to the numbers that display on the bottoms of pages, not the sequential page numbers generated by Word or Acrobat.

Modification/Addition	Page #
"Transaction Agreement" has been changed to "Transaction Specifications" on the cover page and elsewhere in the document. The standard HIPAA meaning of "transaction agreement" is a brief, high level document about trading partner Transaction and Code Set responsibilities. The Transaction Specifications portion of the Companion Document is where we discuss data in detail.	Various
Revision History and Revision Roadmap pages have been added after the cover page to more clearly explain document versions.	N/A
Document headers have been revised to show the transaction name and section name. Footers now have Version Numbers.	Various
Transaction Specifications Sections are in 10 point rather then 9 point Ariel font to improve readability.	Various
"Manual feed" instructions in initial document pages have been removed. The document should print more readily.	N/A
Hawaii's monthly roster/month end process is run the last day of the month.	8 and 10
"AAA" and "AE" Action code values communicate information of interest to health plans and will follow the member's four-character Rate Code in the Insurance Group or Policy Number (REF02) element of the 2000 Member Level Detail Loop of the 834 transaction.	41
"TM" transactions are not, for medical health plans that receive them, disenrollments. They are notifications that members are no longer covered by a behavioral health plan.	40
Med-QUEST uses The Member Identification Number REF Segment in the 2000 Loop of the 834 Transaction in two ways. When "3H" is present in qualifier element REF01, REF02 is the member's Case Number. When "ZZ" is present in REF01, REF02 is the member's Primary HAWI/Med-QUEST ID when another ID was previously assigned and appeared on a prior Roster. "ZZ" is only used on enrollment terminations to be followed by corrected enrollments under the Primary ID.	42

Modification/Addition	Page #
As originally designed, the Member Level Dates DTP Segment is for a variety of dates associated with a member's enrollment with an insurance carrier. Many of the DTP01 qualifier values reflect dates that an employer/sponsor would report to a commercial insurance carrier and are not appropriate for use by a Medicaid Agency. Some forcing of qualifier values to correspond to Med-QUEST situations has been required. As used by Med-QUEST, the three valid values selected for use in DTP01 apply to the following situations: ▪ An "Eligibility Begin" Date (DTP01 = "256") shows the first day of a member's enrollment in a health plan with the same Rate Code and Island. It does not indicate a member's eligibility for Med-QUEST. An "Eligibility Begin" Date always appears for each member on Monthly 834s. On Daily 834's it appears on new enrollments and on changes that affect a member's Island or Rate Code. ▪ An "Eligibility End" Date (DTP01 = "257") appears when a member's enrollment in a particular Island/Rate Code combination is ended. It is only used on Daily enrollment terminations and retroactive "block in/block out" enrollment changes. Monthly 834s show only current members with their current Island and Rate Codes. "Eligibility End" Dates will not appear on Monthly 834s. ▪ A "Maintenance Effective" Date (DTP01 = "303") appears on Daily Changes when the member's Island and Rate Code are not affected. One and only one of these dates will appear for all members on 834 Transactions. "Block in/block out" retroactive enrollments and terminations are the only exception. They involve both Begin and End Dates.	42
The date in the Transaction Set Creation Date (BGN03) element on the 834 Transaction is equivalent to the current Process Date. This is the date on which transaction data is extracted from HPMMIS. It is possible for this date to be prior to the date on which the transaction is sent. We recommend looking in the "outer envelopes" (IEA and GS Segments) for electronic transmission dates.	36
The Companion Document was updated in Section 5.2 under "Valid Values" and "Definition/Format" to replace AHCCCS references with Med-QUEST	34

Modification/Addition	Page #
We recommend that "AA" and "AE" Action Code values appear in a second iteration of the Health Coverage Policy Number REF Segment in Loop 2300 of the 834 Transaction. A REF01 value of "17" (Client Reporting Category) will be associated with an "AA" or "AE" Action Code. When it appears as an Action Code, a value of "AA" or "AE" will appear in REF02. Only Daily Enrollment Adds are affected by this enhancement.	41
On 834 Transactions, Island Code appears in Loop 2100A, Element N406 (Location Identification Code). The associated qualifier (N405) has a value of "CY" (County/Parish). We believe that this is a valid way of designating Hawaiian Islands. An Island Code will always appear for each member on Monthly 834s. On Daily 834s, we would expect it on new enrollments and on Island Code changes.	45
The (67) mentioned in Looop 2100A, Segment NM1, Element NM108, "Identification Code Qualifier" was inadvertently added to this document, but has no relevance for Med-QUEST. It has been removed throughout the document.	Various
The "O" (Other) value was omitted from the Companion Guide. It will be added and cross referenced to an ISO-639 Language Code of "UND" (Undetermined). This refers to Loop 2100A, Segment LUI, Element LUI02, "Language Code." Additionally, the spelling of "Samoan" has been corrected.	47
820 Loop 2000A, Segment ENT, Element ENT01, "Assigned Number" has an incorrect reference. The reference in the Defnition/Format was corrected to be 2000A rather than 2300A.	63

Table of Contents

1. Introduction

1.1 Document Purpose

Companion Documents

Companion Documents are available to external entities (health plans, program contractors, providers, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with Med-QUEST. The following Med-QUEST Companion Documents are being produced:

- *834 Enrollment and 820 Capitation Transactions*
- 270 Eligibility Verification and 271 Eligibility Response Transactions
- 837 Claim Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 276/277 Claim Status Request and Response Transactions
- 278 Prior Authorization Transaction

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. They also address the security and privacy of health data. The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange in health care.

The intent of the law is that all electronic transactions, for which standards are specified, must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by a process that included significant public and private sector input.

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

Document Objective

This Companion Document provides information related to the 834 Enrollment (Daily and Monthly Roster Processes) and the 820 Capitation (Monthly Capitation Payment Process) Transactions and to the ways in which health plans and program contractors receive information from Med-QUEST.

Intended Users

The Companion Documents are intended for the technical staff of the external entities who are responsible for electronic transaction/file exchanges.

Relationship to HIPAA Implementation Guides

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

Companion Documents are intended to supplement rather than replace the standard Implementation Guide for each transaction set. The information in these documents is not intended to:

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

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. Where 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 any such 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.

1.2 Contents of this Companion Document

Introduction	Section 1.0 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2.0 provides an overview of the transactions included in this Companion Document including information on: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted Med-QUEST files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3.0 provides technical information on transmitting electronic data to and receiving electronic data from Med-QUEST including information on: ▪ Setting up a communications link ▪ File Transfer Protocol (FTP) procedures ▪ Security requirements and procedures, including encryption ▪ File naming conventions
Transaction Standards	Section 4.0 provides information relating to the transactions included in this Companion Document including: ▪ General HIPAA transaction standards ▪ Testing criteria and procedures ▪ Data interchange conventions applicable to the transactions ▪ Procedures for acknowledgment transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Agreements	Section 5.0 provides more specific information relating to the transactions sets included in this Companion Document including: ▪ The purpose of transaction agreements between Med-QUEST and other covered entities ▪ Med-QUEST-specific data clarifications for the transactions at the data element level ▪ A detailed Agreement that shows how Med-QUEST populates the data elements in the 834 Enrollment and 820 Capitation Payment Transactions.

2. 834 Enrollment and 820 Capitation Transactions

Transaction Overview

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

In addition, Med-QUEST has moved information from another enrollment-related file, the Med-QUEST TPL File, into the 834 Enrollment Transaction. The 820 Capitation Transaction extracts payment data from Daily and Monthly Roster Files and from the Mass Adjustment File.

834 Enrollment Transaction

The 834 Enrollment Transaction is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy (Med-QUEST) to a health care payer (a Med-QUEST health plan). Monthly 834 Transactions identify all active members of a health plan on a given date and are generated in association with monthly capitation prepayments. Daily 834 Transactions provide data on both an individual's initial enrollment, subsequent changes in enrollment to the health plan, and enrollment terminations. Daily 834 Updates generate partial month payments to new health plan enrollees and positive and negative adjustments caused by retroactive enrollments, disenrollments, and changes from one Rate Code or Island to another.

The Daily 834 Transaction is unique among HIPAA Transactions in that external entities (health plans) use data on it to update their systems. Depending on the system requirements of individual health plans, 820 Transactions may also provide update data in the HIPAA environment. Monthly 834 Transactions are for purposes of audit and enrollment verification and are not intended for use in system updates.

820 Capitation Transaction

Med-QUEST makes all capitation and capitation related payments to health plans on a monthly basis. For each capitated entity that receives 834 Transactions, payment data for monthly capitation payments and daily adjustments appears on the Monthly 820. In addition, positive or negative payments that result from mass capitation adjustments are included on the same Monthly 820 Transaction.

Financial sanctions due to late encounter submission are also reported on the 820 and deducted from health plan payments. The Med-QUEST Fiscal Agent deducts sanction amounts authorized by Med-QUEST from its monthly health plan capitation payments and passes information to the 820, along with Check Numbers and Payment Dates.

The single monthly 820 Transaction that Med-QUEST sends to all health plans serves as a remittance advice but is separate from the health plan's monthly capitation check, now issued by Affiliated Computer Services (ACS), the Med-QUEST Fiscal Agent. Payment totals on the Monthly 820 and the amount of the monthly capitation check should always match.

Processes Replaced or Impacted

The primary processes replaced by the 834 Enrollment and 820 Capitation Transactions are the Daily and Monthly Roster File interfaces. Data from Rosters is augmented by data from the TPL Interface File and split between the two transactions.

834 Enrollment Transaction

Replaced Files
- Daily and Monthly Roster Files (Enrollment components)
- Third Party Liability (TPL) File

Impacted Files
- None

820 Capitation Transaction

Replaced Files
- Daily and Monthly Roster Files (Capitation Payment component)
- Capitation Remittance Advice

Impacted Files
- Mass Adjustment Roster

Payment amounts, check numbers and payment dates on monthly 820 Transactions must match the corresponding information on the checks that the Med-QUEST Fiscal Agent writes to health plans. The Mass Adjustment File is impacted because it contributes to data on the 820 Capitation Transaction.

Other Related Information

Med-QUEST will continue to produce several enrollment-related files in the Agency's original proprietary format. A detailed evaluation of each pre-HIPAA HPMMIS-to-health-plan interface file can be found in Appendix B, Assessment of Roster and Roster-Related Med-QUEST Interfaces.

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 each member's initial enrollment and all subsequent changes in enrollment. 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
- Disenrolled or deceased members for whom the health plan is no longer responsible
- Demographic changes for each member such as changes in name, address or date of birth
- Other changes for each member such as changes in Rate Code or pregnancy status

The Monthly 834 Enrollment Transaction is used to:

- Reconcile the health plan's Member Files
- Audit updates to health plan data applied by Daily 834 Transactions during the previous month

Standard Implementation Guide

The standard Implementation Guide for the 834 Enrollment Transaction is the ANSI Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for Benefit Enrollment and Maintenance and all approved Addenda. Versions of the 834 Enrollment Transaction Implementation Guide and Addenda adopted by Med-QUEST and other covered entities and used in preparation of this document are:

- ASC X12N 834 (004010X095)
- ASC X12N 834 (004010X095A1) (Addenda)

Related Specifications

Specifications for the 820 Capitation Remittance Advice Transaction are closely related to Specifications for the 834 Transaction. All capitation payments and adjustments (with the exception of health plan sanctions) correspond to monthly prepayments, new enrollments, enrollment changes, or Rate Code rate change adjustments (mass adjustments) for individual health plan members.

Transmission Schedules

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

Available at: 10:00 PM daily
Available for: 7 days from the date of processing

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

Available at: 7:00 AM on the morning of the first day of the next month.
Available for: 30 days from the date of processing or until the next Monthly Roster is generated.

For entities that receive both 834 and 820 Transactions, Monthly 834 Enrollment Transaction processing must complete successfully prior to initiation of Monthly 820 Capitation Transaction processing. The single 820 Transaction that Med-QUEST writes to each health plan will then include the next month's capitation pre-payments as well as daily capitation payments and adjustments accumulated during the previous month.

2.3 820 Capitation Transaction

Purpose

The 820 Capitation Transaction is a monthly file that provides each health plan with an electronic remittance advice for its member-level capitation payments. Med-QUEST makes all capitation payments on a monthly basis with a single check to each capitated entity. 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 Rate Code adjustments based on retroactive capitation rate changes by Med-QUEST (mass adjustments)
- Show encounter sanction amounts deducted from payments to health plans

All entities that receive 834 Enrollment Transactions also receive 820 Capitation Payment Transactions for capitation payments associated with health plan enrollments. In addition, several entities that do not qualify as covered HIPAA health plans receive 820 Transactions without 834 Transactions. They are:

- The Community Care Management Corporation (CCMC), Med-QUEST's dental care coordinator
- Cycra in its role as Med-QUEST's reinsurance administrator
- Cycra in its role as administrator of Med-QUEST's State of Hawaii Organ and Tissue Transplantation (SHOTT) Program

Standard Implementation Guide

The Standard Implementation Guides for the 820 Capitation Transaction are the National Electronic Data Interchange (NEDI) Transaction Set Implementation Guide for Payroll Deducted and Other Group Premium Payment for Insurance Products and all approved Addenda. The 820 Capitation transaction guides currently include:

- ASC X12N 820 (004010X061)
- ASC X12N 820 (004010X061A1) (Addenda)

Related Specifications

For health plans that receive 834 Enrollment Transactions, Specifications for the 820 Capitation Remittance Advice Transaction are closely related to Specifications for the 834 Transaction. All capitation payments and adjustments (with the exception of health plan sanctions) correspond to monthly pre-payments, new enrollments, enrollment changes, or Rate Code rate change adjustments (mass adjustments) for individual health plan members.

Transmission Schedules

The 820 Monthly Capitation Transaction file is produced monthly and is generally available to each health plan on the Med-QUEST Communication Server based on the following schedule:

Available at:	7:00 AM on the morning of the first day of the next month.
Available for:	30 days from the date of processing on until the next Monthly 820 Transaction is created.

For entities that receive both 834 and 830 Transactions, Monthly 834 Enrollment Transaction processing must complete successfully prior to initiation of Monthly 820 Capitation Transaction processing. The single 820 Transaction that Med-QUEST writes to each health plan will then include the next month's capitation pre-payments as well as daily capitation payments and adjustments accumulated during the previous month.

3. Technical Infrastructure and Procedures

3.1 Technical Environment

MED-QUEST Data Center Communications Requirements

Trading partners connect to the Med-QUEST Central Site Network by going 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.

General VPN Requirements include:

- Ethernet network interface card or modem
- Minimum of 18 MB of free disk space
- Minimum of 16 MB of RAM (32 MB for NT 4.0)
- Working Internet connection where the firewall can be configured to permit passage of the VPN traffic on TCP port 10000
- Installed VPN Client Software (a preconfigured VPN client is available on the Med-QUEST Web Site)

Further information on connecting to the Med-QUEST FTP Server appears in Section 3.2, File Transfer Protocol Procedures.

Technical Assistance and Help

Med-QUEST's Customer Support Center provides technical assistance related to non-testing related questions about electronic claims submission or data communications interfaces. Contact information is:

- **Telephone Number:** To Be Determined
- **Hours:** To Be Determined
- **Information required for initial call:**
  - Topic of Call ("VPN setup", "FTP procedures", etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (dial-up, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by Customer Support Center

3.2 File Transfer Protocol Procedures

Data Communications Interface Request Procedure

Med-QUEST is currently working to standardize the process for establishing a communications link between health plans and Med-QUEST. Final procedures and forms will be provided to covered entities as soon as they are available.

Health plans must complete the following forms to receive authorization for access to Med-QUEST's FTP server:

- Med-QUEST Electronic Data Exchange Request Form
- Med-QUEST User Affirmation Statement
- Data-specific Authorization Forms

These forms are available in Appendix A. All installation, testing, and implementation schedules are under the control of the Med-QUEST.

MED-QUEST Electronic Data Exchange Request Form

This form is completed by the health plan and describes the kind of the information exchanged between the entity and Med-QUEST. Information in this form answers the questions:

- What organization is the contracting entity?
- Who is authorized to access the data?
- Who will be actually receiving the data, if different from the contracted entity?
- What type of data will be accessible to the entity (e.g., Roster Files, Encounter or Claim Files, Provider Reference Files or electronic Remittance Advice data)?
- How the data exchange will occur (tape, FTP via VPN, Internet or e-mail)?
- What are the entity's User ID and Password?

MED-QUEST User Affirmation Statement

The Med-QUEST User Affirmation Statement outlines the responsibilities associated with access to Med-QUEST data. It requires all employees of the entity who will be authorized to access data using the VPN connection to affirm that they understand and will comply with these responsibilities.

Data-specific Authorization Forms

Med-QUEST is currently consolidating its data-specific authorization forms so that entities will be required to complete just one or two forms instead of one for each type of data, as is the case currently.

Communications Interface

The standard software-to-hardware Virtual Private Network (VPN) connection involves installing VPN client software on each user's computer at a trading partner's site. Each user can then create a VPN tunnel and connect to the Med-QUEST FTP Server. This is the most common type of VPN connection and takes the least amount of time to establish. The process for setting it up is:

- Contact the Med-QUEST Systems Office (808-nnn-nnnn) to receive the guest ID and password necessary to download VPN client software from Med-QUEST. Any entity can receive the password to download the software. The software is downloaded from its own Web Site. The Internet address is also supplied by Med-QUEST.
- Install the software on the user's machine.
- Prepare to configure the software to allow access to the Med-QUEST FTP server. The configuration process is site-specific and requires a second password that can be obtained from ISD Customer Support. Only users who have submitted signed Med-QUEST User Affirmation Statements will be given the password.
- Configure the VPN client software for the Med-QUEST FTP server. ISD Customer Support personnel walk users through the configuration process to ensure that the software is correctly configured. In most cases, the configuration process takes less than one hour to complete.

The software-to-hardware VPN connection requires users to log off from their own networks while connected to the Med-QUEST FTP server. For trading partners for which this limitation is a problem, other options are available. They are more complex than the software-to-hardware connection and are normally used by organizations with high volumes of traffic and sophisticated local area networks (LANs). The set up process is site-specific and requires additional technical information. Contact ISD Customer Support at the above phone number and establish a Problem Ticket if users in your organization need to remain connected to your internal network while accessing the Med-QUEST FTP Server.

File Transfer Procedures

Once connected to the Med-QUEST FTP server via a VPN tunnel, users can transfer files to and from authorized directories using any of many brands of standard FTP software.

3.3 Security Procedures

Security Requirements

Detailed security procedures are currently being finalized by Med-QUEST and will be provided to the covered entities as soon as they are available

Entities that utilize this service will be required to meet various physical and system security requirements as defined by Med-QUEST. Security requirements include:

- All users must sign a User Affirmation Statement regarding security and data confidentiality.
- Assumption of responsibility by individual staff members as well as by the contracted entity.
- Contractors and subcontractors and staff are expected to comply with all Federal, State of Hawaii, and Med-QUEST policies and procedures regarding data confidentiality, security, and user access.

Adding/Changing Access

Entities that wish to add users who are authorized to access data through a VPN tunnel must complete the following steps:

- Have the new user complete and sign a Med-QUEST User Affirmation Statement.
- The individual authorized to add users to the entity's authorized user list must mail and/or fax a copy of the signed User Affirmation Statement to the Med-QUEST Systems Office.
- Med-QUEST will notify the entity's authorized user when the new users account has been established, including the new user's ID and password.

File Encryption Procedures

Encryption is handled automatically by the VPN tunnel. The VPN client software on the user's computer or system will automatically unencrypt the data after it reaches the user's system.

All files and data that pass through the VPN tunnel are encrypted using a 128-bit algorithm and then encapsulated using an algorithm that provides the equivalent of 1024-bit encryption.

3.4 File and Directory Naming Conventions

FTP Directories

Med-QUEST file and directory naming conventions for 834 and 820 Transactions are not yet final. Final conventions will be provided when they are available.

The current directory 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 file naming conventions are as follows:

- FTP\Cust_ID\System\Subsystem\IN(OUT)\Test(Prod)**TBD**

Directory Names:

- Cust_ID – A three character alphabetic representing a commonly recognized acronym for the Health Plan.
- System – The HPMMIS System that the data pertains to such as Health Plan, Recipient, Encounters, Reference or Provider.
- Subsystem - The type of information in the file such as Rosters, TPL, etc.
- IN/OUT. IN identifies a directory when the entity sends the file to Med-QUEST. OUT identifies a directory when Med-QUEST sends the file to the entity.
- TEST/PROD. TEST is for files to be used in the test region. PROD is for production files.

Production Files

The naming conventions shown below are based on current filenames. Final naming conventions are being developed by Med-QUEST.

834 Enrollment Transaction

Add/Change/Delete File (Daily Roster)

- FTP\Cust_ID\HealthPlan\RostersOUT\PROD\YYMMDD.TXT (YYMMDD is the processing date)

Active Members Audit File (Monthly Roster)

- FTP\Cust_ID\HealthPlan\RostersOUT\PROD\YYMM00.TXT (YYMM00 is the month the file represents)

820 Capitation Transaction

- FTP\Cust_ID\HealthPlan\RostersOUT\PROD**TBD**

Test Files

The naming conventions shown below are based on current filenames. Final naming conventions are being developed by Med-QUEST.

834 Enrollment Transaction

Add/Change/Delete File (Daily Roster)

- FTP\Cust_ID\HealthPlan\RostersOUT\TEST\YYMMDD.TXT (YYMMDD is the processing date)

Active Members Audit File (Monthly Roster)

- FTP\Cust_ID\HealthPlan\RostersOUT\TEST\YYMM00.TXT (YYMM00 is the month the file represents)

820 Capitation Transaction

- FTP\Cust_ID\HealthPlan\RostersOUT\TEST**TBD**

4. Transaction Standards

4.1 General Information

HIPAA Requirements

HIPAA standards are specified in the Implementation Guide for each mandated Transaction Set and modified by authorized Addenda. Currently, both the 834 Enrollment and the 820 Capitation Transactions have one draft Addendum each. These Addenda have been adopted as final and are incorporated into Med-QUEST requirements.

An overview of requirements specific to each transaction can be found in Section 2, Data Overview, of the 834 and 820 Implementation Guides. The Data Overview Section contains information related to:

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

Size of Transmissions/ Batches

Transmission sizes are limited by two factors:

- The number of Segments/Records allowed by HIPAA standards
- Med-QUEST file transfer limitations

HIPAA standards for the maximum file size of each transaction are specified in the appropriate Implementation Guide or its authorized Addenda. The 834 Implementation Guide imposes a limit of 10,000 INS Member Level Detail Segments in the 2000 Member Level Detail Loop. Each INS Segment represents an individual member on Monthly 834 Transactions. For Daily 834s, updates for a single member may generate multiple 2000 Loops and INS Segments when there is more than one update Action Code from Med-QUEST.

When more than 10,000 updates (as measured by occurrences of INS Segments) are present, Med-QUEST will create multiple Daily 834 Transactions within the same functional group (GS/GE envelope).

For 820 Capitation Transactions, there is no Implementation Guide limit to the number of individual members on the same transaction. The number of 2000B Individual Remittance Loops on the Monthly 820 Transaction

reflects the number of member-level capitation payments and adjustments performed during the month. For Med-QUEST, 820 Transactions will frequently have with tens or even hundreds of thousands of 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.

Med-QUEST file transfer limits are set by the Med-QUEST Systems Office based on the type of data contained in the transaction set.
For the 834 Enrollment and 820 Capitation Transactions, Med-QUEST is currently in the process of defining any Med-QUEST specific file transfer limitations that may be necessary.

Other Standards

820 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:

- Internal Balancing within the 820 Transaction

  The total amount of the payment to the capitation receiver (820 Element BPR02) must equal the sum of all individual capitation payments (Element RMR04). Because the Implementation Guide's concept of adjustments differs substantially from what Med-QUEST means by capitation adjustments, the 820 Transaction's ADX Adjustment Segments are not used by Med-QUEST.

  For entities paid by aggregated capitation (payment per eligible Med-QUEST recipient rather than per enrolled plan member), 820 payments are reported by individual member. For aggregated capitation contracts (e.g., with the Community Care Management Corporation, the Med-QUEST dental care coordinator), each eligible recipient listed on the 820 has the same payment amount.

  Health plan sanction amounts due to late encounter submissions are applied and reported on the summary rather than the individual member level. Med-QUEST deducts sanction amounts from monthly capitation payments. Sanction withholds are reflected in the Total Payment Amount in Element BPR02 of the 820 Transaction. Other payments and withholds that are not member specific are also handled in this manner.

- Balancing between the 820 Transaction and External Sources

  External balancing involves comparisons between data on 820 Transactions and payment amounts generated by the daily, monthly, and ad hoc vouchers that contribute to monthly health plan payments. The total amount of the payment to the capitation receiver (Element BPR02) is derived from the same voucher amounts used to generate the check. Voucher Numbers appear for all individual and organization level payments on each health plan's monthly 820. They can be used to link payment components to other sources, including 834 enrollment lines with matching Voucher Numbers.

  For Med-QUEST, monthly payments to each health plan can include capitation pre-payments from Monthly 834 Transactions, payments and adjustments from Daily 834 Transactions, Rate Code change adjustments from Mass Adjustment runs, and distributions and withholds that are not member specific.

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. TRN02 carries the Check Number of the check written for capitation payment by the Med-QUEST Fiscal Agent.

Sequence of 2000B Individual Remittance Loops

On the 820 Transactions that it creates, Med-QUEST populates the Individual rather than the Organization Summary version of the 2000 Loop (Loop 2000B rather than 2000A) except when reporting health plan payments or withholds that are not member specific. Each occurrence of 2000B is equivalent to a Daily, Monthly, or Mass Adjustment Roster Record for a health plan member. For each health plan, Med-QUEST's 820 Transactions include all Roster lines created during the past month. Members on each Daily, Monthly, and Mass Adjustment Roster appear in separate groupings. Frequently, the same member appears on more than one 2000B Loop.

The content of Daily, Monthly, or ad hoc Mass Adjustment groupings is the same as the content of the succession of Roster Files that Med-QUEST health plans received in the pre-HIPAA environment. The major difference is that health plans get capitation payment data once a month rather than in smaller, scattered pieces. Health plans may want to read the 2000B Loops in the 820 Transaction as they occur or may wish to apply a preliminary sort. A potential 2000B sort sequence that some health plans may find optimal is by Med-QUEST Recipient ID and, within Recipient ID, by Pay Period Begin Date.

4.2 Testing Procedures

Testing Requirements

Med-QUEST has divided HIPAA Transaction and Code Set testing activities into two parts:

- Internal Validation of Transaction Sets
- Validation of the Electronic Data Exchange Process with Trading Partners

Because 834 and 820 Transactions originate from Med-QUEST, internal validation of these transactions is a Med-QUEST responsibility. However, transaction receivers need to be prepared for the second part of transaction testing. When testing with trading partners, Med-QUEST transmits 834 and 820 Transactions within the interchange and functional envelopes discussed in Section 4.3, Data Interchange Conventions. Med-QUEST expects its trading partners to respond to 834 and 820 transactions from Med-QUEST with TA1 and 997 Transactions, both when test transactions are valid and when they have errors (see Section 4.4, Acknowledgement Procedures and Section 4.5, Rejected Transmissions and Transactions).

Med-QUEST trading partners that receive daily 834 transmissions will also need to test financial updates to their systems from the test 834 Update Transactions sent by Med-QUEST. Trading partners with transaction translators feed standard transactions from Med-QUEST into the translator. The translator converts the incoming transactions into proprietary formats and code sets prior to system updates by 834 and 820 receivers.

Med-QUEST is aware of the extensive variations between pre-HIPAA Roster Files and standard 834 and 820 Transactions. Med-QUEST recommends that its trading partners that receive Daily 834 Transactions be prepared for the major changes in data format and content described in Section 5, Transaction Specifications.

Test Data – Privacy Considerations

Med-QUEST believes that, when possible, use of real-life production data will enhance the overall value of the compliance testing process. However, if covered entities elect to use production data in testing, they must ensure that it remains in compliance with all federal and state privacy regulations.

In particular, Med-QUEST will ensure that data that includes patient identifiable information for use in testing 834 and 820 Transactions is encrypted or eliminated from tests submitted to the certification testing system unless the testing system is in compliance with all HIPAA regulations concerning security, privacy, and business associate agreements. Med-QUEST requires adherence to the same privacy policy by its trading partners.

Testing Procedures

The testing procedures for individual transaction sets will be finalized at a later date. Procedures will be provided to the covered entity in a memorandum prior to the start of testing for a transaction.

Acceptance Procedures

The procedures for accepting testing results for individual transaction sets will be finalized at a later date. Procedures will be provided to the covered entity in a memorandum prior to the start of testing for a transaction.

4.3 Data Interchange Conventions

Overview of Data Interchange

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

An important but not always explicit aspect of ISA Segments is that of separator or delimiter codes. These are values that signify the beginnings and ends of segments, data elements, and for composite elements, data element components. For segments and elements, separator values within the ISA segment dictate the values to be used by all transactions within the outer envelope. For composite elements, Element ISA16 tells receivers the value to be used as a component separator. Separator values, by definition, cannot be used as data.

Transaction Agreements that specify how individual data elements are populated by Med-QUEST on ISA/IEA and GS/GE envelopes are shown in the table beginning on the next page. Both 834 and 820 Transactions are covered.

Definitions of table columns follow:

Segment ID
The Implementation Guide's identifier for a data segment. Unlike full-blown HIPPA Transactions, outer envelopes have segments but not loops.

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. Because elements within the ISA/IEA envelope are of fixed length and always present, element lengths are also provided.

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

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

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION AGREEMENT					
Seg ID	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER					
ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
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.
ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
ISA	ISA04	SECURITY INFORMATION	This 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.
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	30	U.S. Federal Tax Identification Number
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		The Med-QUEST Federal Tax Identification Number
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	30	U.S. Federal Tax Identification Number
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		The receiver's Federal Tax Identification Number
ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 Characters		The Interchange Time in HHMM format
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

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION AGREEMENT					
Seg ID	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
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
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 associated Interchange Trailer IEA02
ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code send by the sender to request an Interchange Acknowledgement (TA1)/1 Character	1	Interchange Acknowledgement Requested
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	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 Character	| (Pipe)	Segment and element level separators are defined by usage in the ISA Segment and do not require separate ISA elements to identify them. Values adopted by Med-QUEST on outgoing transactions are: "~" (tilde) – Segment Terminator "{" (left rounded bracket) – Data Element Separator "|" (Pipe) – Component Separator Separator values, by definition, cannot be used as data, even within free-form messages.
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
IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE TRANSACTION AGREEMENT							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	BE RA	Benefit Enrollment and Maintenance (834) or Payroll Deducted or Other Group Premium Payment for Insurance Products (820) For 834 Transactions, each functional group will consist of transactions with 10,000 or fewer 2000 Loops. For the 820, a functional group will be a single monthly 820 Transaction.	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners.		The same DHS Tax ID used in the ISA Segment.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners.		The same Health Plan Tax ID used in the ISA Segment.	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD.		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender.		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	Responsible Agency Code	Code used in conjunction with Element GS08 to identify the issuer of the standard.	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	Version/Release/Industry Identifier Code	Code identifying the version of the transaction(s) in the functional group.	Different values for 834 and 820	834: 004010X095A1 820: 004010X061A1 These versions of transactions include Addenda.	HIPAA Code Set

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

4.4 Acknowledgment Procedures

Overview of Acknowledgment Processes	**Med-QUEST is currently evaluating and refining the acknowledgement procedures to be performed by its translator. Trading partners will receive information when procedures are final.**
TA1 Interchange Acknowledgment	**Med-QUEST is currently evaluating and refining the acknowledgement procedures to be performed by its translator. Trading partners will receive information when procedures are final.**
997 Functional Acknowledgment	**Med-QUEST is currently evaluating and refining the acknowledgement procedures to be performed by its translator. Trading partners will receive information when procedures are final.**

4.5 Rejected Transmissions and Transactions

Overview of Rejection Process	**Med-QUEST is currently evaluating and refining the acknowledgement procedures to be performed by its translator. Trading partners will receive information when procedures are final.**

5. Transaction Specifications

5.1 About Transaction Specifications

Purpose

Transaction Specifications document the code set values that Med-QUEST allows between trading partners and specify the type and format of the information in data elements. In some cases these values are subsets of the data element values listed in Implementation Guides. In others, they are specific to Med-QUEST requirements.

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

Relationship to HIPAA Implementation Guides

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

The information in the Transaction Agreements is not intended to:

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

5.2 834 Enrollment Transaction Agreement

Overview

The 834 Enrollment Transaction contains information on new member enrollments, enrollment terminations, and changes to information on currently enrolled members. The purpose of the Transaction Agreement 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.

Transaction Specifications Table

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

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

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

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

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

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

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

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

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 within a transaction set		Nine-digit number starting with 000000001 and increasing sequentially. It is unique within a “transaction group” of 834 Transactions on the same transmission and matches the value in the SE02 Element at the end of the transaction.
N/A	BGN	BGN01	Transaction Set Purpose Code	Code identifying purpose of transaction set	00 15 22	Original Transmission Resubmission of an original transaction with corrections where the original transaction had errors and was not processed by the receiver Resubmission of an original transaction with no corrections where the original transaction had errors and was not processed by the receiver Normally, the value will be "00" for an original transaction. The Implementation Guide says that a "15" value is appropriate "when the original transmission was incorrect, has yet to be processed by the receiver, and a new corrected transaction is being sent." The "22" value is used "when the original transaction was lost or not processed, and the sender is passing another transmission that is the same as the original." Note that a Transaction Set Identifier Code (BGN06) entry is required to identify the replaced transaction when the Transaction Set Purpose Code is "15" or "22". If a receiver’s front-end software rejects 834 Transactions from Med-QUEST, the Agency expects to correct the problem that caused the rejection and send a new transmission (BGN01=”00”) with corrected Roster data.
N/A	BGN	BGN02	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set		Nine-digit number starting with 1 and increasing sequentially. According to the Implementation Guide, this is a number that uniquely identifies "this occurrence of the transaction for future reference." This is a unique number within all 834 Transactions ever generated by a sender, not just within a particular transmission.

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	BGN	BGN03	Transaction Set Creation Date	Identifies the date the submitter created the transaction		CCYYMMDD This date is equivalent to the Process Date on pre-HIPAA Rosters. It is the date on which data for the 834 Roster is extracted from HPMMIS.
N/A	BGN	BGN04	Transaction Set Creation Time	Time file is created for transmission		Time expressed in the HHMM format
N/A	BGN	BGN05	Time Zone Code	Code identifying the time zone used in specifying a time	MS	Mountain Standard Time BGN05 is a significant element for Med-QUEST because the standard data interchange convention is to show the time at the location of transaction creation (Phoenix, Arizona).
N/A	BGN	BGN06	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set		BGN02 Transaction Identifier value from the original transaction when BGN01 is '15' or '22'. Not used on original transmissions.
N/A	BGN	BGN08	Action Code	Code indicating type of action	2 4	Change or Update. File contains adds, deletes and/or changes. (Equivalent to Daily Roster) Verify. File contains a snapshot of all active recipients. (Equivalent to Monthly Roster) A "2" value does not necessarily mean that each individual update on a daily transaction has a financial impact. Some daily updates are revenue neutral.
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
1000A	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	P5	Plan Sponsor

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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	F1	Federal Tax ID Number
1000A	N1	N104	Sponsor Identifier	Identification of the party paying for the coverage		The Sponsor Identifier is the Federal Tax ID for Hawaii DHS.
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	F1	Federal Tax ID Number
1000B	N1	N104	Insurer Identification Code	Code identifying the insurer providing coverage		Health Plan Federal Tax ID

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000	INS	INS01	Insured Indicator	Indicates whether the insured is the subscriber or a dependent	Y	The 2000 Member Level Detail Loop is repeated for every health plan member. In addition, on Daily 834s, the loop occurs (with exceptions) once for each Maintenance Reason Code (INS04) translated from the up to eight Med-QUEST Action Codes used on each pre-HIPAA 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, tell health plans what fields to update in their Member Databases. Some HPMMIS Action Codes, however, cannot be translated and INS Segments are created without them. 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
2000	INS	INS03	Maintenance Type Code	Code identifying a specific type of item maintenance	001 or 021 or 024 030	HIPAA Maintenance Type Codes are equivalent to the following pre-HIPAA Action Types from the Daily Roster File: <u>Used when BGN08 = 2 (Daily Roster)</u> Change. Action Code 'C' on current Daily Roster or Addition. Action Code 'A' on current Daily Roster or Termination. Action Code 'D' on current Daily Roster <u>Used when BGN08 = 4 (Monthly Roster)</u> Audit/Compare. No equivalent Med-QUEST Code The Maintenance Type Code in this loop describes the purpose of each 2000 Loop. A separate Maintenance Type Code element (HD01) in the 2300 Health Coverage Loop determines the update function of each 2300 Coverage Loop within the 2000 Loop.

834 ENROLLMENT TRANSACTION AGREEMENT						
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		HIPAA Maintenance Reason Codes are equivalent to the following pre-HIPAA Action Codes from the Daily Roster File: **<u>Current Med-QUEST Values</u>** 02 NB (Newborn) 03 DE (Deceased) 07 AO (Admin Out) BO (Enrollment Block Out) CH (Eligibility Change Disenroll) IE (Ineligible) TM (Mental Health Termination) 14 VW (Voluntary Withdrawal) 21 PG (Pregnant Woman) 22 EI (Open Enrollment) EO (Open Enrollment Out) 25 DB (Date of Birth Change), NC (Name Change) SX (Sex Change) 28 AI (Admin In) BI (Enrollment Block In) EC (Enrollment Choice) RA (Retroactive Enrollment) NE (Normal Enrollment) 29 RC (Rate Code Change) 33 IC (SSN Change) The situational INS04 element will appear on Daily 834s when a reasonable translation can be made between the Med-QUEST Action Code and this HIPAA code set (see above). For Med-QUEST Action Codes other than the ones listed, Element INS04 is not populated. For 2000 Add Loops (INS03 = “021”) on Daily 834s, all data in the loop is used by the receiving health plan to create new member records on its database. For 2000 Termination Loops (INS03 = “024”), only the data elements needed to identify the member and to terminate the member from the receiving health plan are included. For adds and terminations,

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
						the receiving health plan does not need to rely on the Maintenance Reason Code in INS04 to determine what updates to make. For 2000 Change Loops (INS03 = "001"), however, Maintenance Reason Codes are of more value. A Maintenance Reason Code of "25" (Change in Identifying Data Elements), for example, indicates that one of the elements used to identify the member has changed. The receiving health plan must then check to see which of the identifying elements is present on the transaction and move the changed data to its database. In some situations, it is necessary to include some elements on the transaction even when their values have not changed in order to meet HIPAA requirements. The HPMMIS "TM" (Behavioral Health Termination) Action Code is a special situation. It is used to notify a member's medical health plan of the termination of the member's behavioral health coverage. For the receiving medical health plan, this is a change rather than a termination of enrollment.
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		HIPAA Medicare Plan Codes are equivalent to the following pre-HIPAA Medicare Codes from the Daily Roster File: <u>Current Med-QUEST Values</u>
					A	Medicare Coverage A = Y and Medicare Coverage B = N
					B	Medicare Coverage A = N and Medicare Coverage B = Y
					C	Medicare Coverage A = Y and Medicare Coverage B = Y
					E	Medicare Coverage A = N and Medicare Coverage B = N

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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	Date expressed in CCYYMMDD format. Only populated on Daily 834s if Date of Death is present for the member on the PMMIS 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 of Death. This field is only populated on the Daily Roster 834 if BGN08 = “2” (Daily Update Transaction).
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		Med-QUEST ID for member
2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1L	Group or Policy Number
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		The member’s new Rate Code (X[4]) on Daily 834s with new enrollments or Rate Code changes, followed by HPMMIS Action Code values of “AA” (Autoassigned) and “AE” (Enrollment Choice). The Action Codes appear on new enrollments. The member’s current Rate Code is used on Monthly 834s without Action Codes.

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	17 3H ZZ	Client Reporting Category Case Number Mutually Defined This REF Segment can occur up to five times. ▪ 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 "3H" is present, REF02 is the member's Case Number. ▪ When "ZZ" is present, REF02 is the member's Primary HAWI/Med-Quest ID when another ID was previously assigned and appeared on a prior Roster. "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		▪ The Voucher Number for the payment or ▪ The client's Case ID and Relationship Code or ▪ The clients Primary Med-QUEST ID when a different ID is being terminated.
2000	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	256 or 257 or 303	Eligibility Begin or Eligibility End or Maintenance Effective The "Eligibility Begin" or "Eligibility End" Date in this DTP Segment signifies changes in Island or Rate Codes on Daily 834s. Island and/or Rate Code changes trigger capitation payment changes and adjustments on 820 Transactions. On Daily Updates that do not involve Island or Rate Code changes, the date in this field is the Maintenance Effective Date. These dates do not show periods of Med-QUEST eligibility. The Implementation Guide's Qualifier values for Eligibility Dates are the closest fit currently available to critical health plan dates. This DTP Segment can occur up to 20 times. On Monthly Rosters, this segment carries the Begin and/or End Date of the most current Island/Rate Code combination. It is possible for both Begin and End Dates to be present in retroactive enrollment and disenrollment situations.

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in CCYYMMDD format.
2000	DTP	DTP03	Status Information Effective Date	The date that the status information provided is effective		The date described by the qualifier in DTP01.
2100A	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	74 IL	Corrected Insured. This code is used when a change transaction on a Daily 834 Transaction changes a member's name, gender, or date of birth. The Implementation Guide requires this value and population of the 2000B Incorrect Member Name Loop when any of these basic demographic values are changed. Insured/Subscriber. On Daily 834s, this element is used when enrolling a new member or updating a member's Date of Birth or Gender without a name change. "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 name
2100A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	34	Social Security Number.

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	NM1	NM109	Subscriber Identifier	Insured's or subscriber's unique identification number assigned by a payer		Social Security Number. Only used if NM108 above is 34.
2100A	PER	PER01	Contact Function Code	Code identifying the major duty or responsibility of the person or group named	IP	Insured Person. Only populated if a home telephone number for the member is available.
2100A	PER	PER03	Communication Number Qualifier	Code identifying the type of communication number	HP	Home Phone Number. Only populated if a home telephone number for the member is available.
2100A	PER	PER04	Communication Number	Complete communications number including country or area code when applicable		Home Telephone Number. Only populated if a home telephone number for the member is available.
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.
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).

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	N4	N405	Location Qualifier	Code identifying type of location	CY	County/Parish
2100A	N4	N406	Location Identification Code	Code which identifies a specific location		County (Island) Code For Hawaii, N406 is the recipient's Island Code. Island Code, along with Rate Code in the Insurance Group or Policy Number REF Segment, defines Med-QUEST capitation rate categories.
2100A	DMG	DMG01	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in CCYYMMDD format. On Daily Maintenance (but not Monthly or Daily New Enrollment) DMG Segments, these fields are populated only when there are changes or corrections.
2100A	DMG	DMG02	Member Birth Date	The date of birth of the member to the indicated coverage or policy		Date of Birth
2100A	DMG	DMG03	Gender Code	A code indicating the gender of the patient or insured	F M	Female Male

834 ENROLLMENT TRANSACTION AGREEMENT						
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: UN (Unknown/Unspecified) CH (Chinese) FI (Filipino) JA (Japanese) KO (Korean) OA (Other Asians) MI (Mixed OT (Other – include HAWI value of "UN") HI (Hispanic) PR (Puerto Rican) AI (American Indian/Alaskan Native HA (Hawaiian Native) BL (Black not of Hispanic origin) WH (White not of Hispanic origin) OP (Other Pacific Islanders) SA (Samoan) Addenda to the 834 Implementation Guide add several new Race/Ethnicity Code values. Some of these values (including "J" for Native Hawaiian) have been adopted by Med-QUEST.
					7 A E H I J N O P	
2100A	LUI	LUI01	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	LE	ISO 639 Code Set for language Med-QUEST uses the LUI Segment for the primary language spoken in the household.
2100A	LUI	LUI02	Language Code	Code indicating the language spoken by an individual		HIPAA compliant ISU-639 Language Codes are equivalent to the following pre-HIPAA Medicare Codes from the Daily and Monthly Roster Files: C (Chinese, Cantonese) M (Chinese, Mandarin) E (English) H (Hawaiian) I (Filipino, Ilocano) J (Japanese)
					CHI/ ZHO ENG HAW ILO JPN	

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
					KMH KOR LAO PHI SGN SMO SPA TGL TON UND UND VI	B (Cambodian) K (Korean) L (Laotian) F (Filipino, Other) D (Sign Language) N (Samoan) S (Spanish) G (Filipino, Tagalog) T (Tongan) P (South Pacific [other]) O (Other) V (Vietnamese)
2100B	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, thew code in NM101 in Loop 2100A will be IL, and the code in 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 In order to make effective use of HIPAA-compliant Maintenance Reason Code values, all five of the above elements are populated when there is a change in any of them for an enrolled member.
2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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.
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.
2100B	DMG	DMG01	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in format CCYYMMDD. Used when 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 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.
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

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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.
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.
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).

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100G	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	QD	Responsible Person The 2100G Loop is for data that identifies "the person responsible for the member." Med-QUEST uses the loop in three ways: • For the primary person in the member's case (always present) • For the three-part ID Number of the member's eligibility worker (always present) • For the "Medical Payee Address" of the case worker (not the same as the eligibility worker) to whom ID cards for the member are sent (present only when a "Medical Payee Address" appears on the Roster) Two or three 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 a case or an eligibility worker.
2100G	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100G	NM1	NM103	Responsible Party Last or Organization Name	Last name or organization name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The last name of the primary person in the case.
2100G	NM1	NM104	Responsible Party First Name	First name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The first name of the primary person in the case.

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 name or initial of the primary person in the case.
2100G	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	ZZ	Mutually defined
2100G	NM1	NM109	Responsible Party Identifier	The identification number of the individual responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The Section, Unit, and Worker Number of the member's eligibility worker. Format is SUUWW.
2100G	N3	N301	Responsible Party Address Line	Address line of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The first line of the "Medical Payee Address" if it is present on the Roster.
2100G	N3	N302	Responsible Party Address Line	Address line of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The second line of the "Medical Payee Address" if it is present on the Roster.

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100G	N4	N401	Responsible Party City Name	City name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The city of the “Medical Payee Address” if it is present on the Roster.
2100G	N4	N402	Responsible Party State Code	State or province of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The State Code of the “Medical Payee Address” if it is present on the Roster.
2100G	N4	N403	Responsible Party Postal Zone or ZIP Code	Postal ZIP code of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations		The ZIP Code of the “Medical Payee Address” if it is present on the Roster. May be either five or nine digits.
2200	DSB	DSB01	Disability Type Code	An indicator to describe type of disability	1	Short Term Disability Med-QUEST uses the Disability DSB Segment to show that a new enrollee on a Daily 834 is pregnant. This segment can appear for Adds but not for Changes and not for the Monthly 834.
2200	DSB	DSB07	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID (234)	DX	Diagnosis Code. Only populated if DSB01 above is '1'.
2200	DSB	DSB08	Diagnosis Code	An ICD-9-CM Diagnosis Code identifying a diagnosed medical condition	V22	Pregnancy Diagnosis Only populated if DSB01 above is '1'.
2300	HD	HD01	Maintenance	Code identifying a specific		HIPAA compliant Maintenance Type Codes are equivalent to the following

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
			Type Code	type of item maintenance		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). <u>Use when BGN08 = 2 (Daily)</u> 001 Change. Action Code 'C' on Daily Roster 021 Addition. Action Code 'A' on Daily Roster 024 Termination. Action Code 'D' on Daily Roster <u>Use when BGN08 = 4 (Monthly)</u> 030 Audit/Compare. No equivalent MED-QUEST Code Use this element to describe the type of data in the 2300 Health Coverage Loop only, not the 2000 Member Level Detail Loop. The 2300 Loop is repeated within the 2000 Loop for each type of health plan coverage. This loop gives health plans member enrollment information (including enrollments in other health plans and TPL carriers) in terms of coverages and benefits. The loop is repeated for each Med-QUEST health plan, past and present, in which the member is or has been 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. Subsequent 2300 TPL 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 newly enrolled members • On Daily 834s when there is any change to a member’s TPL coverage On Daily 834s, a 2300 Loop should be created only when there is a new

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
						enrollment or a change in coverage for a member in a health plan (including a change in TPL coverage). On monthly 834s, 2300 Loops should appear for all past and present Med-QUEST enrollments. It is possible to have an update to member data on a Daily 834 Roster (for example, a Rate Code change within the same health plan) without a 2300 Loop. However, at least one 2300 Loop will always be present for each member on a Monthly 834.
2300	HD	HD03	Insurance Line Code	Code identifying a group of insurance products	HMO AK DCP	HIPAA compliant Insurance Line Codes are equivalent to the following types of Med-QUEST health plans: Health Maintenance Organization [Medical Health Plans] Mental Health [Behavioral Health Entities] Dental Capitation [Capitated Dental Clinics] This is the field that determines the kind of 2300 Loop that will follow. On Monthly 834s, an HMO loop is required for the medical health plan and the others are situational depending on the presence of current or prior enrollments. If there are multiple past and present enrollments with the same Insurance Line Code, their 2300 Loops are distinguished by the Enrollment Begin and End Dates in DTP03.
2300	HD	HD04	Plan Coverage Description	A description or number that identifies the plan or coverage		The Health Plan Name and, if present, the Prior Health Plan Name, appear in this element. Both names are 25 bytes long in this 50-byte field.

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	303 348 349	Maintenance Effective (Daily 834s only) Benefit Begin Used when a member is enrolled in the product specified in the Insurance Line Code. Benefit End Used when a member is disenrolled from the product 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 and coverage by 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	Date expressed in format CCYYMMDD. 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 Change Date (Daily 834s only), depending on the value of DTP01.
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	ZZ	Mutually Defined
2300	REF	REF02	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered		Contract Type (X[01]) and Behavioral Health Reporting Category (X[01]) . Behavioral Health Reporting Category appears only for behavioral health coverages.
2320	COB	COB01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	U	Unknown

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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		Four fixed length fields are used to populate this element with its maximum length of 30 characters: TPL Code (X[2]) TPL Policy Number (X[20]) Last Modification Date (YYMMDD) Absent Parent Indicator (X[1]) The sub-fields are positional within the Insured Group or Policy Number element. Spaces are present if data is not available. Sub-field lengths reflect actual data lengths. They sometimes differ from the field lengths in HPMMIS and in the pre-HIPAA Roster.
2320	COB	COB03	Coordination of Benefits Code	Code identifying whether there is a coordination of benefits	5	Unknown
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		Insurer Name
2320	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	344 or 345	Begin Date for Other Insurance Coverage or End Date for Other Insurance Coverage Create two DTP Segments if both dates are present (for retroactive enrollments and disenrollments).
2320	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in format CCYYMMDD. Used when DTP01 above is populated.
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.

834 ENROLLMENT TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 1 to 10 digits.
N/A	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		Nine-digit number starting with 000000001 and increasing sequentially. This number will be the same number that it is in data element ST02 at the beginning of the transaction.

5.3 820 Capitation Transaction Specifications

Overview

The purpose of these Transaction Specifications is Agreement 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 capitation payments. It serves as a detailed capitation remittance advice that shows capitation payments and adjustments for each member, as well as payments and withholds that are not member specific. The 820 Transaction represents the financial aspect of the pre-HIPAA Daily and Monthly Roster Files.

The Med-QUEST Fiscal Agent implements Agency policy by writing monthly capitation checks 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.

According to the Med-QUEST Requirements Document for the 820 Transaction dated October 30, 2002, the following entities receive 820 Transactions from Med-QUEST:

- Medical Heath Plans (AlohaCare, Kaiser, and HMSA)
- Dental Clinics that receive partial capitation
- 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)
- Community Care Services [for adult mental health] administered by HMSA
- The Program of All Inclusive Care for the Elderly (PACE) when it is implemented by Med-QUEST
- Cyrca for reinsurance administration (820 without 834)
- Cyrca for State of Hawaii Organ and Tissue Transplantation (SHOTT) administration (820 without 834)
- Community Care Management Corporation (CCMC) for dental care coordination (820 without 834)

Transaction Specifications Table

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

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

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

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

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

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

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

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

820 CAPITATION TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
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		Nine-digit number starting with 1 and increasing sequentially. This number is unique within the "transaction group" of one or more 820 Transactions on an electronic transmission. It matches the value of Element SE02 at the end of the transaction.
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 Advice
N/A	BPR	BPR02	Total Premium Payment Amount	The total premium payment for this batch or transaction		Total premium payment for the transaction Med-QUEST generates a single Monthly 820 Capitation Transaction for each health plan. The monthly transaction reflects all capitation payments and adjustments on Daily and Monthly 834s during the previous month. Adjustments from Daily 834 can be positive or negative. Mass adjustments (retroactive adjustments for all members with particular Rate Codes) are not reported on Rosters but are included with Roster data in the same Monthly 820 Transaction for each health plan. The amount in this field should always match the monthly check amount paid to the health plan by the Med-QUEST Fiscal Agent.
N/A	BPR	BPR03	Credit or Debit Flag Code	Code indicating whether amount is a credit or debit	C	Credit Following CMS guidelines, negative payment amounts in BRP02 are handled with a Credit Flag of "C" and a negative value in BPR02.
N/A	BPR	BPR04	Payment Method Code	Code identifying the method for the movement of payment instructions	CHK	Check At this time, Med-QUEST does not pay its health plans electronically.
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.

820 CAPITATION TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
N/A	TRN	TRN01	Trace Type Code	Code identifying the type of reassociation which needs to be performed	3	Financial Reassociation Trace Number - The payment and remittance information have been separated and need to be reassociated by the receiver.
N/A	TRN	TRN02	Check or EFT Trace Number	Check number or Electronic Funds Transfer (EFT) number that is unique within the sender/receiver relationship		The Check Number returned to HPMMIS by the Fiscal Agent's Financial System.
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		Health Plan ID Number
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 will be the earliest payment date affected by a retroactive adjustment 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 expressed in format CCYYMMDDCCYYMMDD.
N/A	DTM	DTM06	Coverage Period	The coverage period associated with this premium payment		Payment From/Payment Thru Dates
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

820 CAPITATION TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
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
1000A	N3	N301	Receiver Address Line	The receiver's address line		Health Plan or Agency Street Address Line 1
1000A	N3	N302	Receiver Address Line	The receiver's address line		Health Plan or Agency Street Address Line 2
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
1000B	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer
1000B	N1	N102	Premium Payer Name	Name identifying the organization remitting the payment	MED-QUEST	Name of organization making the payment.
1000B	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer ID Number

820 CAPITATION TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
1000B	N1	N104	Premium Payer Identifier	Number identifying the organization remitting the payment		DHS Tax ID Number
1000B	N3	N301	Premium Payer Address Line	Address line for the premium payer's address		Med-QUEST Street Address Line 1
1000B	N4	N401	Premium Payer City Name	The city name of the premium payer's address		Med-QUEST City
1000B	N4	N402	Premium Payer State Code	State postal code of the premium payer's address		Med-QUEST State
1000B	N4	N403	Premium Payer Postal Zone or ZIP Code	The postal zone code of the premium payer's address		Med-QUEST ZIP Code
2000A	ENT	ENT01	Assigned Number	Number assigned for differentiation within a transaction set		The 2000A Loop is for "group level premium or capitation payments." For Med-QUEST, such payments are always negative and involve health plan sanctions deducted from monthly capitation payments. Within each 820 Transaction, ENT01 starts with 000001 in the six-character Assigned Number element and increments by 1 for each member. Sanction loops, if present, should be assigned the initial number or numbers in ENT01.
2000A	ENT	ENT02	Entity Identifier Code	Code identifying an organization entity, a physical location, property or an individual	2L	Corporation This is the only valid value for this element.
2000A	ENT	ENT03	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer's Identification Number
2000A	ENT	ENT04	Identification Code	Code identifying a party or other code		The DHS Tax ID Number
2000A	RMR	RMR01	Reference Identification Qualifier	Code qualifying the reference identification	1L	Group or Policy Number

820 CAPITATION TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
2000A	RMR	RMR02	Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		For the 2000A Loop, Med-QUEST inserts the Payment Voucher Number (X[9]).
2000A	RMR	RMR04	Detail Premium Payment Amount	The amount paid		The amount of the payment or withhold (withholds, including sanctions, are negative numbers).
2000B	ENT	ENT01	Assigned Number	Number assigned for differentiation within a transaction set		The 2300B Loop is for "detailed remittance information", including the per member payment amount for capitation pre-payments (Monthly Rosters) and adjustments (Daily Rosters and Mass Adjustment Rosters) . For adjustments that appear in the 2320B Loop, the original payment amount will be zero. This approach is necessary to meet the transaction balancing requirements in the 820 Implementation Guide. Within each 820 Transaction, ENT01 starts with 000001 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 sanction withholds are 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 Med-QUEST ID (HAWI ID)

820 CAPITATION TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
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
2100B	NM1	NM105	Individual Middle Name	Middle name of an individual to whom specific remittance amounts apply		Member's Middle Initial
2100B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	34	Social Security Number. The SSN only appears when it has been verified in HPMMIS.
2100B	NM1	NM109	Individual Identifier	Identification number for an individual to whom specific remittance amounts apply		Social Security Number. Only used if NM108 above is 34.
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 will string 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])**

820 CAPITATION TRANSACTION AGREEMENT						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Value**	**Definition/Format**
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 appear in this element. The definition of an adjustment for the 820 Transaction is quite different from Med-QUEST's concept of capitation adjustments and the ADX Adjustment Segment is not used.
2300B	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	582	Report period
2300B	DTM	DTM05	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	Range of dates expressed in format CCYYMMDDCCYYMMDD.
2300B	DTM	DTM06	Coverage Period	The coverage period associated with this premium payment		Capitation Coverage Period for the member 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.
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 1 to 10 digits.
N/A		SE02	Transaction Set Control Number	The unique identification number within a transaction set		Nine-digit number starting with 000000001 and increasing sequentially. This number has the same value as data element ST02 at the beginning of the transaction.

Appendix A - Data Communications Interface Forms

A.1 Electronic Data Exchange Request Form

This form will not be finalized until after the translator software has been installed.

A.2 User Affirmation Statement

This form will not be finalized until after the translator software has been installed.

A.3 Data-Specific Authorization Forms

This form will not be finalized until after the translator software has been installed.

Appendix B - Assessment Of Roster And Roster-Related Med-Quest Interfaces

Interface File	Entity Relationship	Purpose Assessment	Data Assessment	Recommendation
Daily Rosters to Medical Health Plans (currently AlohaCare, Kaiser, and HMSA)	Health Plan (Med-QUEST) to Health Plan	To inform Med-QUEST Health Plans of new members, terminating members and changes in membership on a daily basis. Consistent with the 834 update option.	Most, but not all, current Daily Roster data is accommodated by the 834 Transaction.	HIPAA compliance required. Replace the current Daily Roster File with 834 update transmissions. Move payment data to the 820.
Daily Rosters to Dental Health Plans (Partially Capitated Dental Clinics)	Health Plan (Med-QUEST) to Health Plan	To inform partially capitated Med-QUEST Dental Clinics of new members, terminating members and changes in membership on a daily basis. Consistent with the 834 update option.	Most, but not all, current Daily Roster data is accommodated by the 834 Transaction.	HIPAA compliance required. Replace the current Daily Roster File with 834 update transmissions. Move payment data to the 820.
Daily Rosters to Children's Behavioral Health Agencies (currently Department of Health/Early Intervention Program (DOH/EIP) and Childrens and Adolescent Mental Health Division [CAMHD])	Health Plan (Med-QUEST) to Health Plan	To inform Department of Health behavioral health agencies of new members, terminating members and changes in membership on a daily basis. Consistent with the 834 update option.	Most, but not all, current Daily Roster data is accommodated by the 834 Transaction.	HIPAA compliance required. Replace the current Daily Roster File with 834 update transmissions. Move payment data to the 820.

Interface File	Entity Relationship	Purpose Assessment	Data Assessment	Recommendation
Daily Rosters to the Program of All-Inclusive Care for the Elderly (PACE) will be needed when Med-QUEST takes over this program. PACE is a waiver program currently provided through the Social Services Division (SSD) of the Hawaii Department of Human Services (DHS), not Med-QUEST.	Health Plan (Med-QUEST) to Health Plan	To inform PACE of new members, terminating members and changes in membership on a daily basis. Consistent with the 834 update option.	Most, but not all, current Daily Roster data is accommodated by the 834 Transaction.	HIPAA compliance required in the future when PACE is administered by Med-QUEST. When this happens, use the 834 Update Transaction as the Med-QUEST Daily Roster.
Daily Rosters to the Adult Behavioral Health Agency (Community Care Services [CCS])	Health Plan (Med-QUEST) to Business Associate paid by tiered rates for case management and FFS for other services	To inform CCS of new members, terminating members and changes in membership on a daily basis. Consistent with the 834 update option.	Most, but not all, current Daily Roster data is accommodated by the 834 Transaction.	HIPAA compliance not required because CCS is a fee-for-service business associate of Med-QUEST's rather than an at risk health plan. Also, CCS rather than Med-QUEST enrolls Med-QUEST recipients. However, Med-QUEST will use the 834 Transaction as an Enrollment Roster because CCS is administered by HMSA and HMSA (in its role as a medical health plan) must receive 834s.
Daily Rosters to Cyrca in its role as Med-QUEST's reinsurance administrator	Health Plan (Med-QUEST) to Business Associate paid for reinsurance administration	To inform Cyrca of health plan members with reinsurance claims.	Data on the current Daily Roster is adequate.	HIPAA compliance not required. Continue sending the Daily Roster in its current format.
Daily Rosters to Cyrca in its role as the State of Hawaii Organ and Tissue Transplantation (SHOTT) administrator	Health Plan (Med-QUEST) to Health Plan	To inform Cyrca of information necessary to perform transplant assessments for selected Med-QUEST recipients.	Data on the 834 Transaction is not adequate for transplant program enrollment. Additional clinical data is required.	Although Cyrca, in its role as SHOTT administrator, qualifies as a HIPAA health plan, the 834 Transaction lacks much of the data needed for SHOTT enrollment. Continue sending enrollment data manually.

Interface File	Entity Relationship	Purpose Assessment	Data Assessment	Recommendation
Daily Rosters to the Community Care Management Corporation (CCMC) in its role as Med-QUEST's dental care coordinator	Health Plan (Med-QUEST) to Business Associate paid aggregated capitation for dental case management.	To inform CCMC of recipients eligible for dental services.	CCMC is satisfied with the data on its current Daily Roster.	HIPAA compliance not required. Continue sending the Daily Roster in its current format.
Monthly Rosters to Medical Health Plans (currently AlohaCare, Kaiser, and HMSA)	Health Plan (Med-QUEST) to Health Plan	To inform Med-QUEST Medical Health Plans of the members currently enrolled with them for purposes of audit and reconciliation.	Most, but not all, current Monthly Roster data is accommodated by the 834 Transaction.	HIPAA compliance required. Replace the current Monthly Roster File with 834 Verification transmissions. Move payment data to the 820.
Monthly Rosters to Dental Health Plans (Partially Capitated Dental Clinics)	Health Plan (Med-QUEST) to Health Plan	To inform partially capitated Med-QUEST Dental Clinics of the members currently enrolled with them for purposes of audit and reconciliation.	Most, but not all, current Monthly Roster data is accommodated by the 834 Transaction.	HIPAA compliance required. Replace the current Monthly Roster File with 834 Verification transmissions. Move payment data to the 820.
Monthly Rosters to Children's Behavioral Health Agencies (currently Department of Health/Early Intervention Program [DOH/EIP] and Childrens and Adolescent Mental Health Division [CAMHD])	Health Plan (Med-QUEST) to Health Plan	To inform Department of Health behavioral health agencies of the members currently enrolled with them for purposes of audit and reconciliation.	Most, but not all, current Monthly Roster data is accommodated by the 834 Transaction.	HIPAA compliance required. Replace the current Monthly Roster File with 834 Verification transmissions. Move payment data to the 820.

Interface File	Entity Relationship	Purpose Assessment	Data Assessment	Recommendation
Monthly Rosters to the Program of All-Inclusive Care for the Elderly (PACE) will be needed when Med-QUEST takes over this program. PACE is a waiver program currently provided through the Social Services Division (SSD) of the Hawaii Department of Human Services (DHS), not Med-QUEST.	Health Plan (Med-QUEST) to Health Plan	To inform PACE of the members currently enrolled with them for purposes of audit and reconciliation..	Most, but not all, current Monthly Roster data is accommodated by the 834 Transaction.	HIPAA compliance required in the future when PACE is administered by Med-QUEST. When this happens, use the 834 Verification Transaction as the Med-QUEST Monthly Roster.
Monthly Rosters to the Adult Behavioral Health Agency (Community Care Services [CCS])	Health Plan (Med-QUEST) to Business Associate paid by tiered rates for case management and FFS for other services	To inform CCS of the members currently enrolled with it for purposes of audit and reconciliation.	Most, but not all, current Monthly Roster data is accommodated by the 834 Transaction.	HIPAA compliance not required because CCS is a fee-for-service business associate of Med-QUEST's rather than an at risk health plan. Also, CCS rather than Med-QUEST enrolls Med-QUEST recipients. However, Med-QUEST wants to use the 834 Transaction as an enrollment roster because CCS is administered by HMSA and HMSA (in its role as a medical health plan) must receive 834s.
Monthly Rosters to Cyrca in its role as Med-QUEST's reinsurance administrator	Health Plan (Med-QUEST) to Business Associate paid by non-capitated rates for reinsurance administration	To inform Cyrca of health plan members with reinsurance claims.	Data on the current Monthly Roster is adequate.	HIPAA compliance not required. Continue sending the Monthly Roster in its current format.
Monthly Rosters to Cyrca in its role as the State of Hawaii Organ and Tissue Transplantation (SHOTT) administrator	Health Plan (Med-QUEST) to Health Plan	To inform Cyrca of information necessary to perform transplant assessments for selected Med-QUEST recipients.	Data on the 834 Transaction is not adequate for transplant program enrollment. Additional clinical data is required.	Although Cyrca, in its role as SHOTT administrator, qualifies as a HIPAA health plan, the 834 Transaction lacks much of the data needed for SHOTT enrollment. Continue sending enrollment data manually.

Interface File	Entity Relationship	Purpose Assessment	Data Assessment	Recommendation
Monthly Rosters to the Community Care Management Corporation (CCMC) in its role as Med-QUEST's dental care coordinator.	Health Plan (Med-QUEST) to Business Associate paid aggregated capitation for dental case management.	To inform CCMC of recipients eligible for dental services.	CCMC is satisfied with the data on its current Monthly Roster.	HIPAA compliance not required. Continue sending the Monthly Roster in its current format.
Annual Enrollment Prospective Transaction File	Health Plan (Med-QUEST) to Health Plan	To provide health plans with basic demographic information for members changing health plans. This information is for transition preparation only, not legal notification of plan membership.	Identification and demographic data on members potentially joining and leaving each health plan. Includes the member's previous Health Plan Number.	Not appropriate for the 834 Transaction. Information is not legal notification of enrollment.
Medicare Crossover Eligibility File	Health Plan agent (HMSA-MMIS) to Medicare	An unsolicited "roster" of dual eligibles. Does not enroll anyone in Medicare.	Basic Med-QUEST and Medicare eligibility data.	Not appropriate for the 834 Transaction. Does not perform an enrollment function.
PBM Eligibility File	Health Plan (Med-QUEST) to PBM.	To inform Pharmacy Benefit Managers (PBMs) of their Med-QUEST membership.	Data on member demographics and eligibility.	PBMs are Med-QUEST business associates rather than health plans. They do not receive Enrollment Rosters or require the 834 Transaction.
PBM Eligible TPL File	Health Plan (Med-QUEST) to PBM.	To inform PBMs of COB/TPL data on their Med-QUEST membership.	Data on member coordination of benefits.	PBMs are Med-QUEST business associates rather than health plans. They do not receive Enrollment Rosters or require the 834 Transaction.
PMB Address File	Health Plan (Med-QUEST) to PBM.	To inform PBM of address data on their Med-QUEST membership.	Data on member addresses.	PBMs are Med-QUEST business associates rather than health plans. They do not receive Enrollment Rosters or require the 834 Transaction.
PBM Exception File	Health Plan (Med-QUEST) to PBM.	To inform PBM of specific member eligibility data (members enrolled in a hospice) on their Med-QUEST membership.	Data on specific member eligibility data	PBMs are Med-QUEST business associates rather than health plans. They do not receive Enrollment Rosters or require the 834 Transaction.
PBM Nursing Home File	Health Plan (Med-QUEST) to PBM.	To inform PBM of specific member eligibility data (members in nursing home) on their Med-QUEST membership.	Data on specific member eligibility data	PBMs are Med-QUEST business associates rather than health plans. They do not receive Enrollment Rosters or require the 834 Transaction.

Interface File	Entity Relationship	Purpose Assessment	Data Assessment	Recommendation
Premium Share Billing File	Health Plan (Med-QUEST) to Premium Share Billing Service	To bill QUEST members for their share of premium payments.	Data on amounts owed to QUEST by Premium Share members.	Not appropriate for the 834 Transaction. Does not perform an enrollment function.
Daily HAWI Enrollment File	HPMMIS (Med-QUEST) to HAWI (eligibility determination)	To identify enrollment for all Med-QUEST active recipients.	Enrollment data on active recipients.	Files received from federal, state and county government eligibility determination agencies involving jointly administered government programs containing eligibility files are explicitly excluded from HIPAA requirements.
Monthly Public Safety Department (PSD) Eligibility File	HPMMIS (Med-QUEST, a health plan) to PSD (non Health Plan)	To inform PSD of recipients active on Med-QUEST file.	Eligibility data on active PSD recipients.	HIPAA compliance not required. This is a transaction between a covered entity (Med-QUEST) and a non covered entity (PSD).
Monthly Office of Youth Services (OYS) Eligibility File	HPMMIS (Med-QUEST, a health plan) to (OYS) (non Health Plan)	To inform OYS of recipients active on Med-QUEST file.	Eligibility data on active PSD recipients.	HIPAA compliance not required. This is a transaction between a covered entity (Med-QUEST) and a non covered entity (OYS)
Quarterly FFS Recon File	Health Plan agent (HMSA-MMIS) to Health Plan (HPMMIS)	To verify and reconcile health plan enrollment. The file will no longer exist when HPMMIS is implemented for Claims.	Enrollment data on health plan members.	This file is no longer needed. All processing will be handled by HPMMIS.
TPL File to Cyrca in its role as Med-QUEST's reinsurance administrator	Health Plan (Med-QUEST) to Business Associate for reinsurance administration	To inform Cyrca of COB/TPL data on its Med-QUEST membership.	Data on member coordination of benefits.	HIPAA compliance not required. Continue sending the TPL File in its current format.
TPL File to Cyrca in its role as the State of Hawaii Organ and Tissue Transplantation (SHOTT) administrator	Health Plan (Med-QUEST) to Health Plan	To inform SHOTT of COB/TPL data on its Med-QUEST membership.	Data on the 834 Transaction is not adequate for transplant program enrollment. This file contains data on member coordination of benefits.	Because the 834 is not adequate for the transplant program enrollment and enrollment will continue to be sent manually, continue to send the existing TPL file in its current format.
TPL Daily File to all health plans	Health Plan (Med-QUEST) to Health Plan	To inform health plans of other health care coverage available to their members.	Member identification and demographic information, along with information on other carriers and policies. Almost all file data is present on the 834 Transaction.	Use TPL/COB data in 834 Transactions. Replace the TPL Daily File with the 834.