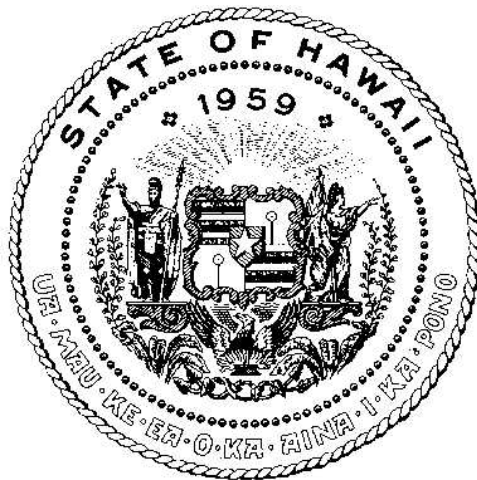


Hawaii PMMIS

Hawaii Prepaid Medical Management Information System

Health Plan Manual

Encounters



HIPAA Compliant Version 1.1
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Table of Contents

1	Preface	1
1.1	Overview	1
1.2	Encounter Data Processing.....	1
1.3	Conventions Used in this Manual.....	1
2	Encounter Interface.....	2
2.1	Encounter Data	2
2.1.1	Encounter Data Reporting	2
2.1.2	Encounter Definitions.....	2
2.1.2.1	Encounter	2
2.1.2.2	Header Record	2
2.1.2.3	Detail Record	3
2.1.2.4	Encounter Categories	3
2.2	Encounter Record Submission Requirements.....	5
2.2.1	Monthly Processing Cycle.....	5
2.2.2	Media for Encounter Submissions	5
2.2.3	Pre-Syntax Processing	6
2.2.3.1	Individual Encounters Failing Pre-Syntax	6
2.2.3.2	Full Encounter Submissions Failing Pre-Syntax	6
2.2.4	Full Edit/Audit Processing.....	7
2.2.5	Duplicates	8
2.2.5.1	Pharmacy.....	8
2.2.5.2	Dental	8
2.2.5.3	UB92 Specific	8
2.2.5.4	HCFA 1500 Specific	9
2.2.6	Correcting Pended Encounters.....	9
2.3	Reference Sources	10
2.4	Preparing Data for Submission	10
2.4.1	Record Type Inpatient (I)	10
2.4.1.1	Interim Inpatient Stays	11
2.4.1.2	Separate Admissions.....	11
2.4.2	Record Type Outpatient (O).....	11
2.4.3	Record Type Drug (D).....	11
2.4.4	Record Type Miscellaneous (M)	12
2.4.5	Encounter Record Relationship to Standard Claim Forms.....	12
2.4.6	Reporting Encounters Using Default Provider Information.....	17
2.4.6.1	Conditions for Physician Default	17
2.4.6.2	Conditions for Non-Physician Default	17
2.4.6.3	Conditions for Physician and Facility Default	18
2.4.7	Required Data Elements.....	19

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

2.5	Penalties	24
2.5.1	Submitting Timely Data	24
2.5.2	Submitting Accurate Data	25
2.5.3	Submitting Complete Data	25
3	Appendices	26
3.1	Appendix 4A – Encounter File Formats.....	26
3.1.1	QUEST Encounter Header Input Record	26
3.1.2	QUEST Encounter Detail Input Record.....	28
3.1.3	Encounter File Header Record	29
3.1.4	Encounter File Trailer Record	29
3.2	Appendix 4B –Encounter Codes and Values	30
3.2.1	Claim Status Reason Codes	30
3.2.2	Default Provider IDs.....	31
3.2.3	Location Codes.....	31
3.2.4	Provider Reimbursement Status Codes.....	32
3.2.5	Z Codes	32
3.2.6	Revenue Codes	33
3.2.7	Place of Service Codes.....	34
3.3	Appendix 4C – Encounter Error Reports.....	35
3.3.1	QUEST Encounter Pre-Syntax Error Report (EN000641).....	35
3.3.2	QUEST Encounter Input Error Detail Report (EN000241)	35
3.3.3	File Header Record Format (Encounter Error Reports 641/241)	36
3.3.4	File Trailer Record Format (Encounter Error Reports 641/241)	36
3.4	Encounter Reporting	37
3.4.1	Duplicate ERI by Error Code Report (ECHAR179)	37
3.4.2	QUEST Hawaii Cycle Encounter Report (ECHAR947)	38
3.5	Appendix 4D – Encounter Data Elements.....	39
3.5.1	HCP ID.....	39
3.5.2	Encounter Record ID Number.....	39
3.5.3	Encounter Detail Number.....	39
3.5.4	Transaction Code	40
3.5.5	Record Type	40
3.5.6	Receipt Date	40
3.5.7	HAWI Client ID.....	41
3.5.8	HCP Claim ID	41
3.5.9	Original Encounter Record ID Number	41
3.5.10	Quest Billing Provider ID Number	42
3.5.11	Birth Date.....	42
3.5.12	Gender.....	42
3.5.13	Patient Status	43
3.5.14	Primary Diagnosis Code	43
3.5.15	Date Of Onset.....	43
3.5.16	Total Billed Amount.....	44

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

3.5.17	Total Reimbursed Amount	44
3.5.18	Total Copayment Amount	44
3.5.19	Total TPL Amount	45
3.5.20	Type Of Admission	45
3.5.21	Encounter Covers From Date	45
3.5.22	Encounter Covers Through Date	46
3.5.23	Inpatient Admission Date	46
3.5.24	Inpatient Discharge Date	46
3.5.25	Type Of Facility	47
3.5.26	Bill Classification	47
3.5.27	Frequency	47
3.5.28	Covered Days	47
3.5.29	Other Diagnosis Codes	48
3.5.30	Principal ICD-9 Procedure Code	48
3.5.31	Other ICD-9 Procedure Codes	48
3.5.32	Rendering Provider ID Number	49
3.5.33	Referring/Attending/Prescribing Provider ID	49
3.5.34	Location Of Service	50
3.5.35	Service Type	50
3.5.36	Begin (From) Date	50
3.5.37	Through (To) Date	51
3.5.38	Diagnosis Code 1	51
3.5.39	Other Diagnosis Codes	52
3.5.40	Place Of Service	52
3.5.41	HCPCS Code	52
3.5.42	Revenue Code	53
3.5.43	NDC Code	53
3.5.44	Dental Code	53
3.5.45	Procedure Code Modifier	54
3.5.46	Tooth/Quadrant Identifier	54
3.5.47	Tooth Surface Codes	54
3.5.48	Quantity	55
3.5.49	Days Supply	55
3.5.50	Provider Reimbursement Status	55
3.5.51	Billed Amount	56
3.5.52	Reimbursed Amount	56
3.5.53	Copayment Amount	56
3.5.54	TPL Flag	57
3.5.55	Claims Status Reason Code	57
3.6	Appendix 5A – Med-QUEST/Health Plans File Transfers	58
3.6.1	Overview	58
3.6.2	Virtual Private Network (VPN)	58
3.6.3	Availability	58
3.6.4	Login	58
3.6.5	Filenames	59
3.6.6	Encounter Filenames	59

**Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters**

3.6.7	Directory Structure	60
3.6.8	Production Folder	60
3.6.9	Test Folder.....	60
3.6.10	Production and Test Subfolders.....	61
3.6.10.1	Encounter	61
3.6.10.2	Reports	61
3.7	Health Plan IDs	62
4	Contacts	63
4.1	Systems Office	63
5	Addendums to Health Plan Manual – Encounter	64

1 Preface

1.1 Overview

The Health Plan Manual - Encounter is distributed to medical, dental, and behavioral health plans contracting with the Hawaii Department of Human Services (DHS), Med-QUEST Division (MQD) to further their understanding of the Hawaii Prepaid Medical Management Information System (HPMMIS). HPMMIS is operated and maintained by the State of Arizona Medicaid agency known as the Arizona Health Care Cost Containment System Administration (AHCCCS). This manual contains the encounter file layouts and process to be used by health plans to provide encounter information to and receive information from MQD through HPMMIS.

1.2 Encounter Data Processing

Encounter data for services provided to eligible members are submitted electronically by health plans to HPMMIS. Encounters are edited by HPMMIS, and either accepted (adjudicated), rejected, or pended. HPMMIS provides MQD with reports on processed encounters and health plans with error files.

1.3 Conventions Used in this Manual

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

CMS	Centers for Medicare & Medicaid Services
DHS	Department of Human Services
FTP	File Transfer Protocol
HAWI	Hawaii Automated Welfare Information System
HCFA	Health Care Financing Administration
Health Plan	Health plans include medical, dental, and behavioral health plans contracted with the State of Hawaii to provide services to eligible members.
HPMMIS	The Hawaii Prepaid Medical Management Information System is based on the Arizona PMMIS and is operated and maintained by the State of Arizona for Hawaii.
MQD	MQD is the Med-QUEST Division of the Hawaii Department of Human Services.
TPL	Third Party Liability
VPN	Virtual Private Network

2 Encounter Interface

2.1 Encounter Data

Each health plan is required to maintain and submit encounter data to the Med-QUEST Division in accordance with the request for proposal contract and the Health Plan Manual. All encounter data must conform to the data element specifications defined in this section.

2.1.1 Encounter Data Reporting

The health plan can submit its encounter information electronically bi-monthly based on the scheduled submittal times. The encounter information must be submitted via the FTP process described in section 3.6 Appendix 5A – Med-QUEST/Health Plans File Transfers.

2.1.2 Encounter Definitions

2.1.2.1 Encounter

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

All services by one provider for one visit relative to a specific condition. A single physician visit for multiple conditions will be considered a single encounter.

An inpatient encounter is defined as the entire hospital confinement or inpatient stay. All facility services incurred during the inpatient stay are part of the inpatient encounter, including the emergency room visit prior to and resulting in the hospital admission.

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

2.1.2.2 Header Record

A header record is the static client/recipient and provider information common to most claim forms. The specific data elements for the header record are listed in section 3.1.1 QUEST Encounter Header Input Record.

2.1.2.3 Detail Record

A detail record is service-specific data that appear in different formats on different claim forms as claim lines. Refer to section 3.1.2 QUEST Encounter Detail Input Record for the specific list of data elements.

2.1.2.4 Encounter Categories

Encounters currently submitted fall into the following four categories:

New encounters are designated by the transaction code (N) and refer to those encounters that have not been processed through a full encounter cycle. They include encounters submitted for the first time as well as encounters resubmitted after being rejected due to pre-syntax failure of processing the file. Encounters that failed pre-syntax are placed in the .641 error file.

Resubmitted encounters are designated by the transaction code (R) and refer to those encounters that have been previously submitted, were fully edited, and found to have error conditions. Encounters with these error conditions are placed in the .241 error file. Encounters designated by the transaction code (R) are encounters that are being resubmitted by the health plan with corrections. When resubmitting an encounter, the Encounter Record ID field must have a new ERI and the Original ERI Record ID field must contain the ERI of the original submission record that is being corrected.

Void encounters are designated by the transaction code (V) and refer to the elimination of a previously submitted and accepted or pended encounter. Any costs incurred are being recovered. Encounters with this transaction code must have an associated Claims Status Reason Code identifying the reason why this encounter is being voided. A voided encounter can not be sent in the same batch file as the original encounter that is being voided. Along with the Claims Status Reason Code, the Encounter Record ID field must have a new ERI and the Original ERI Record ID field must contain the ERI of the original submission record that is being voided.

Adjustment encounters are designated by the transaction code (A) and refer to encounters previously submitted, to which an adjustment (change) is being made. Encounters with this transaction code must have an associated Claims Status Reason Code identifying the reason why this encounter is being adjusted. HPPMIS is not capable of processing a negative submission. To reflect a reversal or similar transaction the health plan must submit the final encounter only, i.e., if a plan submits an encounter for \$100.00 and later finds that the payment should have been \$50.00, the plan would resubmit an encounter for \$50.00, the correct total. Do not submit an encounter for -\$50.00. An adjusted encounter can not be sent in the same batch file as the original encounter that is being adjusted. Along with the Claims Status

Reason Code, the Encounter Record ID field must have a new ERI and the Original ERI Record ID field must contain the ERI of the original submission record that is being adjusted.

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

Medical Services

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

Dental Services

- Preventive care
- Non-emergency services
- Emergency services
- Referrals
- Diagnostic/radiology services
- Pharmaceutical services
- Transportation services

Behavioral Services

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

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

- Over-allowance services
- Excluded services
- Out-of-service area services
- Out-of-plan services

- Individual services reimbursed FFS under global fees and similar reimbursement schemes
- Actual service codes, even if downcoded for settlement purposes

2.2 Encounter Record Submission Requirements

Eighty percent of the encounter data should be received by DHS no later than 120 days from the end of the month in which the service was rendered. One hundred percent of the encounters must be received within 15 months of the end of the month in which the service was rendered. All encounters are expected to be received accurate and in the proper format. The 120-day submission requirement applies only to new encounter data submissions. Adjustment and resubmitted encounters will not be subject to the 120-day submission requirement. In addition, TPL related encounters will not be subject to the 120-day submission deadline. Penalties for tardy encounter submissions are described in the Request for Proposal (RFP) which served as the basis of the contract between the health plan and the Med-QUEST Division.

The following sections present proper data submission requirements.

2.2.1 Monthly Processing Cycle

Encounter processing occurs during the 1st and 3rd Wednesdays of the month. In order for encounters to be included in the cycle, all encounter submissions must be placed on MQD's FTP Server within the pre-set schedule. DHS has the right to change the encounter-reporting deadline with 60 days advance notification to the health plans.

2.2.2 Media for Encounter Submissions

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

Formatting and specific requirements for encounter data is specified in section 3.1.1 QUEST Encounter Header Input Record.

All data fields must be submitted in capital letters.

2.2.3 Pre-Syntax Processing

All encounter submissions used for production data are processed through a “pre-syntax” program (that is, a front-end edit check) to ensure that the submission is readable and to validate the presence and format of the data.

All submissions will generate a .641 Pre-Syntax report that will be returned to the health plan on the MQD FTP Server.

Encounter submissions that fail the pre-syntax edit check are not processed, and therefore still at risk of failing the 120-day submission deadline. Health plans should correct and return the submissions to HPMMIS during the next regularly scheduled bi-monthly submission cycle. The return submission must be submitted with transaction code V or R, a new ERI and the original ERI placed in the Original Encounter Record ID field.

2.2.3.1 Individual Encounters Failing Pre-Syntax

If an individual encounter failed the pre-syntax edits a message will be returned on the .641 report stating that the encounter was not processed. If the individual encounter fails pre-syntax that encounter was not processed by HPMMIS and health plans should correct and return the submissions to HPMMIS during the next regularly scheduled bi-monthly submission cycle.

2.2.3.2 Full Encounter Submissions Failing Pre-Syntax

The entire encounter file may also fail the Pre-Syntax Processing for various reasons. If the entire file fails pre-syntax a .641 Pre-Syntax report will be returned to the health plan on the MQD FTP server with an error message on the second to last line of the file stating why the encounter file failed pre-syntax. If the entire file fails pre-syntax none of the encounters in that file were processed by HPMMIS and health plans should correct and return the submissions to HPMMIS during the next regularly scheduled monthly submission cycle.

All files submitted to the Encounter Subsystem, at a minimum, must include the following fields. Should these minimum fields not be complete, the file will not be accepted into the database. A (.641) Pre-Syntax Error Report will be returned to the health plan outlining the failed areas.

- All encounters in a submission must be for the same Health Plan ID.
- The percent of errors must not exceed the predetermined percentage rate (15%) from the job control file.
- Health Plan ID field must be present on the Encounter File Header Record.

- File type code (EN) must be present on the Encounter File Header Record.
- Number of encounters processed must match total record count (Encounter File Trailer Record). The total record count includes the Encounter File Header Record, all encounters (detail lines), plus the Encounter File Trailer Record, i.e. all encounters +2.
- Health Plan ID must be present and be the same on each Input Record. This ID must also match the Health Plan ID on the Encounter File Header Record.
- Encounter Record ID must be the same number on the QUEST Encounter Header Input Record as the QUEST Encounter Detail Input Record.
- QUEST Encounter Header Input Record must use Encounter Detail No "00000".
- QUEST Encounter Detail Input Record must use Encounter Detail No "00001", "00002", "00003", etc.
- Transaction Code (N, R, V, A) must be present and valid
- If Transaction Code is an R, V or A, the Original Encounter Record ID field must be present and valid.
- HAWI ID must be present.
- QUEST Billing Provider ID must be present and valid on the QUEST Encounter Header Input Record.
- QUEST Rendering Provider ID must be present and valid on the QUEST Encounter Detail Input Record.
- Service Begin Date must be present and valid on the QUEST Encounter Detail Record.
- Billed Amount must be present and valid on both the QUEST Encounter Header and Detail Input Record.
- Line numbers must be numeric and in proper numerical sequence (00000, 00001, 00002, etc).
- Current Date field on File Header Record must match Current Date Field on File Trailer Record.

2.2.4 Full Edit/Audit Processing

Encounter submissions that meet pre-syntax requirements are accepted and loaded into the HPMMIS database. Accepted submissions are processed through the full range of edits/audits during the processing cycle. All encounters that pass the editing/auditing process will be accepted as adjudicated or approved encounters. All other encounters that have passed the pre-syntax requirements but have not passed the edits/audits processing will be committed to the database as pended. Pended encounters will be reported to the health plans via the .241 Encounter Input Detail Report, for correction and resubmission.

2.2.5 Duplicates

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

All records from the same submission that have already been adjudicated or pended,

AND

All records currently on file in the HPMMIS system that were previously adjudicated or are currently in a pended status.

2.2.5.1 Pharmacy

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

- HAWI ID
- Service provider ID
- Date of service
- First nine digits of the NDC

2.2.5.2 Dental

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

- HAWI ID
- Service provider ID
- Procedure code
- Procedure modifier
- Service begin date

2.2.5.3 UB92 Specific

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

- HAWI ID
- Service provider ID
- Bill type
- Total bill amount (from the last encounter detail line containing revenue code '0001' or '001')
- Service begin date
- Service end date

2.2.5.4 HCFA 1500 Specific

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

- HAWI ID
- Service provider ID
- Procedure code
- Procedure modifier
- Primary diagnosis code
- Service begin date
- Service end date

2.2.6 Correcting Pended Encounters

Encounters that do not pass the editing/auditing process performed during the full cycle are committed to the database and flagged as pended. The health plan will be notified within 5 to 9 working days of submission via the .241 Encounter Input Detail Report of the encounters that are in a pend status.

Error reports and control totals will be provided for each health plan. These reports will provide detailed error information with summary control totals of the number of encounters that rejected or pended.

An error extract file will be developed for return to each health plan. Error extract files will be available to the health plans via secure FTP. The format and contents of the error extract file are specified in section 3.3 Appendix 4C – Encounter Error Reports.

Pended encounters should be reviewed, corrected, and resubmitted in subsequent processing cycles. Resubmitted encounters must be identified by the resubmit (R) transaction code and the original ERI in the Original Encounter Record ID field.

2.3 Reference Sources

The following reference sources are used to edit the encounters.

Code Set Description	Source of Information	Updated
HCPCS Level I (CPT)	American Medical Association	Annual
HCPCS Level II (Alpha-Numeric)	Health Care Financing Administration (HCFA)	Annual
HCPCS Level III (State & Local Codes)	DHS/Med-QUEST Division	As requested
CDT-2000	American Dental Association	Annual
ICD-9 Codes / Surgical	Health Care Financing Administration (HCFA)	Annual
ICD-9 Codes / Diagnosis	Health Care Financing Administration (HCFA)	Annual
Revenue Codes	Health Care Financing Administration (HCFA)	Annual
State Revenue Codes	DHS/Med-QUEST Division	As requested
National Drug Codes	Federal Drug Administration (from First Data Bank)	Weekly
State Repackaging Codes	DHS/Med-QUEST Division	As requested

2.4 Preparing Data for Submission

When reporting encounter data to DHS, a health plan must apply the following guidelines to categorize encounter data. Encounter data is reported using four different record types. Each is described below. Note: Only one record type may be included in a single record set. Submission of multiple record types in a single record will result in the file failing the pre-syntax edit and the file will be rejected.

2.4.1 Record Type Inpatient (I)

The inpatient encounter record type should be used to report facility services such as inpatient hospital and institutional services. A maximum of 99 detail lines can be submitted for each encounter of this record type. Do not use this record type for inpatient physician visits or other professional services. Services provided by professional and technical medical providers, hospital-affiliated clinic providers, or persons normally reporting services by an HCFA-1500 claim form are to be reported as record type miscellaneous (M). Services using the (I) record type are usually reported on UB-92 claim forms or other institutional claim forms.

2.4.1.1 Interim Inpatient Stays

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

2.4.1.2 Separate Admissions

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

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

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

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

2.4.2 Record Type Outpatient (O)

The outpatient encounter record type should be used to report medical-facility-based outpatient services, such as hospital emergency room, DME, Hospice, Home Health, diagnostic services provided by facilities, and dialysis services. Also to be reported on this record type are ancillary services for long-term care, sub-acute and waitlist levels of care. Outpatient facility services using this record type have been billed on UB-92 claim forms. A maximum of 99 detail lines can be submitted for each encounter of this record type. Services provided by professional and technical medical providers, hospital-affiliated clinic providers, or persons normally reporting services by an HCFA-1500 claim form are to be reported as record type miscellaneous (M).

2.4.3 Record Type Drug (D)

The drug encounter record type should be used to report NDC-identified drug and medical supplies services dispensed by an outpatient pharmacy, other than inpatient pharmacy. Use the Blue Book from First Data Bank. A maximum of 99 detail lines can be submitted for each encounter of this record type.

2.4.4 Record Type Miscellaneous (M)

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

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

Services using this record type are typically associated with HCFA 1500 claim forms, dental claim forms, or transportation claim forms. Translation and taxi services are also reported as miscellaneous record type. A maximum of 99 detail lines can be submitted for each encounter of this record type.

2.4.5 Encounter Record Relationship to Standard Claim Forms

The design of the encounter record is based upon a specified set of data elements required for HEDIS as well as other reporting requirements for HCFA and the Med-QUEST Division. To translate the encounter data requirements into common business reporting requirements, a crosswalk has been developed for detailed comparison.

The Encounter to Claim Form Crosswalk table that follows identifies each field of the encounter and compares it to each standard and professionally accepted claim form used by commercial providers. The form locator, or the field number, is identified for each claim for each corresponding data element. Unless otherwise specified, these standardized data elements should use standard reference values. Please refer to section 3.5 Appendix 4D – Encounter Data Elements for frequently used reference tables. Specific tables have been supplemented with state-specific, local payer values.

There are unique Med-QUEST data elements for which claim form derivatives do not exist. The reference values for these data elements are also contained in section 3.5 Appendix 4D – Encounter Data Elements and section 3.7 Health Plan IDs.

In regard to data mapping, the encounter data element Record Type can also be compared to a standard claim form. For record types I and O, the corresponding claim form is the UB-92. Depending on the type of service, record type M corresponds to either the HCFA-1500 for medical services, or the ADA claim form for dental services.

The Encounter to Claim Form Crosswalk presents the following information in each column of the table.

ID – Identifies the encounter locator field number on either the Header or Detail Record.

Data Element – Identifies the name of the data element on the Encounter Record.

UB-92 – Identifies the location of the encounter data element on the UB-92 claim form. For values of None, the data element is not an UB-92 field. For values of N/A, the data element is not required on the encounter for record types I and O.

1500 – Identifies the location of the encounter data element on the HCFA-1500 claim form. For values of None, the data element is not an HCFA-1500 field. For values of N/A, the data element is not required on the encounter for record types M.

ADA – Identifies the location of the encounter data element on the ADA dental claim form. For values of None, the data element is not an ADA field. For values of N/A, the data element is not required on the encounter for record types M.

Comments – Identifies specific data requirements pertinent to data mapping.

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

ID	Data Element	UB-92	1500	ADA	Comments
1-H, 1-D	HCP ID	None	None	None	
2-H, 2-D	Encounter Record ID	None	None	None	
3-H, 3-D	Encounter Detail No	None	None	None	
4-H, 4-D	Transaction Code	None	None	None	
5-H, 5-D	Record Type	None	None	None	
6-H, 6-D	Receipt Date	None	None	None	
7-H, 7-D	Quest Client ID	60	1.a	10	
8-H	QUEST Billing Provider ID	51	33 PIN	24	
9-H	Birth date	14	3	7	
10-H	Gender	15	3	6	
11-H	Patient Status	22	N/A	N/A	Values from uniform billing have been supplemented with state-specific codes.
12-H	Primary Diagnosis Code	67	21.1	None	
13-H	Date of Onset	N/A	14	30-32	
14-H	Total Billed Amount	47	28	41	
15-H	Total Reimbursed Amount	None	None	None	
16-H	Total Copayment Amount	57	None	None	
17-H	Total TPL Amount	54	291	42	
18-H	Type of Admission	19	N/A	N/A	Values from uniform billing have been supplemented with state-specific codes.
19-H	Encounter Covers From Date	6	N/A	N/A	
20-H	Encounter Covers Through Date	6	N/A	N/A	
21-H	Inpatient Admission Date	17	N/A	N/A	
22-H	Inpatient Discharge Date	6	N/A	N/A	For type of bill XX1 and XX4, this is the 'Statement covers period THROUGH' date.
23-H	Type of Facility	4	N/A	N/A	First digit
24-H	Bill Classification	4	N/A	N/A	Second digit
25-H	Frequency	4	N/A	N/A	Third digit
26-H	Covered Days	7	N/A	N/A	
27-H / 34-H	Other Diagnosis Codes (1-8)	68-75	21.2-21.4	N/A	
35-H	Principal ICD-9 Procedure Code	80	N/A	N/A	
36-H / 40-H	Other ICD-9 Procedure Codes (1-5)	81A-E	N/A	N/A	

**Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters**

ID	Data Element	UB-92	1500	ADA	Comments
41-H, 39-D	HCP Claim ID	None	None	None	
42-H, 40-D	Original Encounter Record ID	N/A	N/A	N/A	

Detail-Specific Information					
ID	Data Element	UB-92	1500	ADA	Comments
8-D	Rendering Provider ID	51	33 PIN	1 or 24	
9-D	Referring/Attending/Prescribing Provider ID	82	17a	N/A	Follow UB-92 instructions; for 1500, use for specialty referrals, laboratory, radiology, PT, OT, speech, and podiatry; for record type D, report prescribing provider.
10-D	Location of Service	1	33	22	
11-D	Service Type	None	None	None	
12-D	Begin (From) Date	6	24.A	37	For UB-92, 'Statement Covers Period FROM'. For 1500, 'Date(s) of Service From'. For ADA, 'Date service performed'.
13-D	Through (To) Date	6	24.A	37	For UB-92, 'Statement Covers Period THROUGH'. For 1500, 'Date(s) of Service To'. For ADA, 'Date service performed'.
14-D/17-D	Diagnosis Codes 1-4	N/A	24.E	N/A	Actual ICD-9 DX code(s) associated with the service should be reported.
18-D	Place of Service	N/A	24.B	28	For ADA, convert to 2-digit HCFA Place of Service Codes.
19-D	Procedure Code	44	24.D	37	For ADA, use ADA CDT-2 codes. Field name is Procedure Number.
20-D	Revenue Code	42	N/A	N/A	Revenue codes 092 Total Allowable and 095 Total Charges are not required. If submitted, the values will be set to zero.
21-D	NDC Code	N/A	N/A	N/A	NDC Codes are reported on record type D.

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

Detail-Specific Information					
ID	Data Element	UB-92	1500	ADA	Comments
22-D	Dental Code	44	24.D	37	For UB-92 and 1500, if ADA CPT-2 codes are accepted by the health plan, they should be reported in these fields. For ADA, use ADA CDT-2 codes. Field name is Procedure Number.
23-D	Procedure Code Modifier	N/A	24.D	None	For 1500, field name is Modifier.
24-D	Tooth/Quadrant Identifier	N/A	None	37	For ADA, field name is 'Tooth # or letter'.
25-D/29-D	Tooth Surface Codes 1 – 5	N/A	None	37	For ADA, field name is Surface.
30-D	Quantity	46	24.G	N/A	
31-D	Days Supply	N/A	N/A	N/A	
32-D	Provider Reimbursement Status	None	None	None	
33-D	Billed Amount	47	24.F	37	
34-D	Reimbursed Amount	None	None	None	
35-D	Copayment Amount	None	None	None	
36-D	TPL Flag	50	11.d	14-18	
37-D	Claim Status Reason Code	None	None	None	

2.4.6 Reporting Encounters Using Default Provider Information

DHS has determined that there are justifiable instances in which a health plan may not be able to identify a rendering provider. With the agreement of the health plans, DHS has devised a set of default identifiers to be used to default the Billing and Rendering Provider IDs. The three categories of default identifiers are listed below.

2.4.6.1 Conditions for Physician Default

Resident physician in a residency training program

Physician working in the Emergency Room

Anesthesiologist

Physician serving as a PCP in a clinic

Radiologist who reads x-ray reports done in an Emergency Room

Cardiologist/Internist who reads electrocardiograms done in an Emergency Room

2.4.6.2 Conditions for Non-Physician Default

- Physical Therapist
- Occupational Therapist
- Speech Pathologist/Therapist or Audiologist
- Hearing Aid Technician
- Vision Provider who furnishes services related to eyeglasses, contact lenses, low vision aids, etc.
- Nurse Practitioner
- Non-licensed physician/psychologist who provided direct medical care services
- Social Worker who provided case management, counseling, etc.
- Non-emergency transportation
(e.g., taxicab, handicab, handivan driver, etc.)
- Foreign Language or Sign Language Translator
- Meals and Lodging

2.4.6.3 Conditions for Physician and Facility Default

- Physician/facility which provided care (usually on an emergency basis) who/which cannot be identified by the plan
- Physician/facility located out of state, who/which cannot be identified by the plan

The list of valid values of provider default IDs is located in section 3.2.2 Default Provider IDs. If a health plan needs to report encounters from other types of providers, which it cannot identify individually, it should contact the MQD Research Officer.

For accuracy in reporting, the use of default providers should be kept to a minimum. If it is expected that a provider will be used on a continuing basis, that provider should be submitted on the HPPN and a valid QUEST ID assigned. Consequently, Default Provider's are already identified to the system and as such should not be reported in a health plans HPPN submissions.

2.4.7 Required Data Elements

The following matrix provides a record type comparison of field level, data element requirements. Values found in the table indicate whether the data element is required in all instances (Y), or conditionally required (C). The Required Data Elements Matrix presents the following information in chart format.

ID – Identifies the encounter locator field number on either the Header or Detail Record.

Data Element – Identifies the name of the data element on the Encounter Record.

Record Type I, O, D, M – Identifies the requirement for each record type: Inpatient, Outpatient, Drug, and Miscellaneous respectively.

Note: Requirements for Miscellaneous may be different depending on medical and dental service types.

Comments – Identifies specific data requirements pertinent to data mapping.

ID	Data Element	Record Type					Comments
		I	O	D	M medic al	M dental	
1-H, 1-D	HCP ID	Y	Y	Y	Y	Y	
2-H, 2-D	Encounter Record ID	Y	Y	Y	Y	Y	
3-H, 3-D	Encounter Detail No	Y	Y	Y	Y	Y	
4-H, 4-D	Transaction Code	Y	Y	Y	Y	Y	
5-H, 5-D	Record Type	Y	Y	Y	Y	Y	
6-H, 6-D	Receipt Date	Y	Y	Y	Y	Y	
7-H, 7-D	Quest Client ID	Y	Y	Y	Y	Y	
8-H	QUEST Billing Provider ID	Y	Y	Y	Y	Y	Provider ID of individual providers, facilities, groups, clinics, etc. to whom payment is rendered. This field should be populated with rendering provider, if same as billing provider.

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

ID	Data Element	Record Type					Comments
		I	O	D	M medic al	M dental	
9-H	Birth date	Y	Y	Y	Y	Y	If birth date information is not available the plans will be required to override null fields with information reported on the claims.
10-H	Gender	Y	Y	Y	Y	Y	If gender information is not available the plans will be required to override null fields with information reported on the claim.
11-H	Patient Status	Y					
12-H	Primary Diagnosis Code	Y	Y	Y	Y	Y	For I and O, this is not the admitting diagnosis. For D, use 7999 unless a specific diagnosis is entered. For the following MM use 7999: non-emergency transportation, translation, and meals/lodging. For MD use 525 unless a specific diagnosis is entered.
13-H	Date of Onset				C	C	Required for pregnancy and accidents.
14-H	Total Billed Amount	Y	Y	Y	Y	Y	
15-H	Total Reimbursed Amount	Y	Y	Y	Y	Y	
16-H	Total Copayment Amount	Y	Y	Y	Y	Y	
17-H	Total TPL Amount	C	C	C	C	C	

**Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters**

ID	Data Element	Record Type					Comments
		I	O	D	M medic al	M mental	
18-H	Type of Admission	Y					Values from the Uniform Billing tables have been supplemented with state-specific codes.
19-H	Encounter Covers From Date	Y	Y				
20-H	Encounter Covers Through Date	Y	Y				
21-H	Inpatient Admission Date	Y	C				Required for I. For O report effective date of election of Hospice Benefit/start date of home health care services.
22-H	Inpatient Discharge Date	C					Required if there is a discharge: YY1; YY4 in Form Locator 4; not required for interim encounters: YY2; YY3.
23-H	Type of Facility	Y	Y				
24-H	Bill Classification	Y	Y				
25-H	Frequency	Y	Y				
26-H	Covered Days	Y	C				Report for O records if provided.
27-H / 34-H	Other Diagnosis Codes (1-8)	C	C	C	C	C	Do not duplicate the principal diagnosis. Report if provided.
35-H	Principal ICD-9 Procedure Code	Y	Y				
36-H / 40-H	Other ICD-9 Procedure Codes (1-5)	C	C				Report if provided.
41-H, 39-D	HCP Claim ID	Y	Y	Y	Y	Y	
42-H, 40-D	Original Encounter Record ID	C	C	C	C	C	Required if Transaction Code is A, R, or V.

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

ID	Data Element	Record Type					Comments
		I	O	D	M medic al	M dental	
8-D	Rendering Provider ID	Y	Y	Y	Y	Y	
9-D	Referring / Attending / Prescribing Provider ID	Y	C	Y	C		For I, this is the physician primarily responsible for the inpatient care. For O, this is physician requesting the service / supply / treatment. If patient is self-referred to the emergency room, null. For D, this is the prescribing physician. For M, this is the physician (usually PCP who orders specialty care, laboratory, radiology, consultation, podiatry, OT, PT, speech, vision, and rehabilitation services). For M, required for previously mentioned services (in italics).
10-D	Location of Service	Y	Y	Y	Y	Y	
11-D	Service Type	Y	Y	Y	Y	Y	
12-D	Begin (From) Date	Y	Y	Y	Y	Y	
13-D	Through (To) Date	Y	Y	Y	Y	Y	For O, MM, and MD using span billing, separate dates of service must be reported if same service is not provided each day. For reporting a single date of service, replicate the Begin (From) Date field.

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

ID	Data Element	Record Type					Comments
		I	O	D	M medic al	M dental	
14-D/17-D	Diagnosis Codes 1 - 4				C	C	Required field for MM to reflect the diagnosis (diagnoses) for which a procedure was delivered. Conditionally required, if multiple diagnoses are reported as related to a procedure, all diagnoses reported as applicable to a valid HCPCS code should be reported.
18-D	Place of Service				Y	Y	
19-D	Procedure Code		C		Y	C	For O, conditionally required for revenue codes designated by the State as requiring HCPCS coding. Conditionally required for Dental encounters that do not report an ADA code.
20-D	Revenue Code	Y	Y				
21-D	NDC Code			Y			
22-D	Dental Code					Y	For MM, use ADA codes for dental services that are the responsibility of the medical plans.
23-D	Procedure Code Modifier				C	C	
24-D	Tooth/Quadrant Identifier					C	For MD, required for specific ADA codes.

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

ID	Data Element	Record Type					Comments
		I	O	D	M medic al	M dental	
25-D/29-D	Tooth Surface Codes 1 – 5					C	For Dental, required for specific ADA codes.
30-D	Quantity	Y	Y	Y	Y	Y	
31-D	Days Supply			Y			
32-D	Provider Reimbursement Status	Y	Y	Y	Y	Y	
33-D	Billed Amount	Y	Y	Y	Y	Y	
34-D	Reimbursed Amount	Y	Y	Y	Y	Y	
35-D	Copayment Amount	C	C	C	C	C	Required if reported.
36-D	TPL Flag	Y	Y	Y	Y	Y	
37-D	Claim Status Reason Code	C	C	C	C	C	Required for submittals of denials, adjustments, and voids.

2.5 Penalties

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

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

2.5.1 Submitting Timely Data

Timeliness involves the period of time between the date of service and the provision of the encounter data to DHS and the period of time between the deadline for submission of the data and the time the data is provided. Each QUEST Plan is required to report eighty percent of its encounters within 120 days of the end of the month in which the service was rendered. The remaining twenty- percent may be reported after the 120 days, but no later than 15 months from the month in which the service was rendered. The State will conduct a retrospective review of the plan's 15 months of encounter

reporting and will determine whether the plan has met the requirements for timeliness of reporting.

2.5.2 Submitting Accurate Data

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

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

2.5.3 Submitting Complete Data

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

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

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

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

3 Appendices

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

3.1 Appendix 4A – Encounter File Formats

3.1.1 QUEST Encounter Header Input Record

#	Data Name	Size	Type	Actual Position		Remarks
				From	To	
1	Health Plan ID	6	AN	1	6	QUEST assigned health plan identifier
2	Encounter Record ID	20	AN	7	26	HP assigned unique encounter number
3	Encounter Detail No	5	N	27	31	Always 00000
4	Transaction Code	1	AN	32	32	N = New, R = Resubmit, V = Void, A = Adjustment
5	Record Type	1	AN	33	33	H = Header Record
6	Receipt Date	8	N	34	41	CCYYMMDD; health plan receipt date of encounter
7	HAWI Client ID	10	AN	42	51	HAWI assigned client ID number
8	QUEST Billing Provider ID	8	AN	52	59	QUEST assigned provider ID number
9	Birth Date	8	N	60	67	CCYYMMDD
10	Gender	1	AN	68	68	F = female; M = male;
11	Patient Status	2	AN	69	70	Inpatient status (01–42)
12	Primary Diagnosis Code	6	AN	71	76	ICD-9-CM/DSM-4 code
13	Date of Onset	8	N	77	84	CCYYMMDD; date of accident or LMP date if maternity related
14	Billed Amount	8	N	85	92	999999V99; total billed for all services
15	Reimbursed Amount	8	N	93	100	999999V99; total reimbursed for all services
16	Copayment Amount	8	N	101	108	999999V99; total co-payments for all services
17	TPL Amount	8	N	109	116	999999V99; total TPL amount for all services
18	Type of Admission	1	AN	117	117	Type of inpatient admission (inpatient only)
19	Encounter Covers From Date	8	N	118	125	CCYYMMDD
20	Encounter Covers Through Date	8	N	126	133	CCYYMMDD
21	Inpatient Admission Date	8	N	134	141	CCYYMMDD (inpatient only)
22	Inpatient Discharge Date	8	N	142	149	CCYYMMDD (inpatient only)

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

#	Data Name	Size	Type	Actual Position		Remarks
				From	To	
23	Type of Facility	1	N	150	150	Type of facility code
24	Bill Classification	1	N	151	151	Bill classification code
25	Frequency	1	N	152	152	Frequency code
26	Covered Days	3	N	153	155	999
27	Other Diagnosis Code 1	6	AN	156	161	ICD-9-CM/DSM-4 code
28	Other Diagnosis Code 2	6	AN	162	167	ICD-9-CM/DSM-4 code
29	Other Diagnosis Code 3	6	AN	168	173	ICD-9-CM/DSM-4 code
30	Other Diagnosis Code 4	6	AN	174	179	ICD-9-CM/DSM-4 code
31	Other Diagnosis Code 5	6	AN	180	185	ICD-9-CM/DSM-4 code
32	Other Diagnosis Code 6	6	AN	186	191	ICD-9-CM/DSM-4 code
33	Other Diagnosis Code 7	6	AN	192	197	ICD-9-CM/DSM-4 code
34	Other Diagnosis Code 8	6	AN	198	203	ICD-9-CM/DSM-4 code
35	Principal ICD-9 Procedure Code	4	N	204	207	ICD-9-CM procedure code
36	Other ICD-9 Procedure Code 1	4	N	208	211	ICD-9-CM procedure code
37	Other ICD-9 Procedure Code 2	4	N	212	215	ICD-9-CM procedure code
38	Other ICD-9 Procedure Code 3	4	N	216	219	ICD-9-CM procedure code
39	Other ICD-9 Procedure Code 4	4	N	220	223	ICD-9-CM procedure code
40	Other ICD-9 Procedure Code 5	4	N	224	227	ICD-9-CM procedure code
41	HP Claim ID	20	AN	228	247	HP assigned claim ID
42	Original Encounter Record ID	20	AN	248	267	Encounter record ID from a previously submitted encounter

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

3.1.2 QUEST Encounter Detail Input Record

#	Data Name	Size	Type	Actual Position		Remarks
				From	To	
1	HP ID	6	AN	1	6	QUEST assigned health plan Identifier
2	Encounter Record ID	20	AN	7	26	HP assigned unique encounter number
3	Encounter Detail No	5	N	27	31	Service record sequence number from 00001 to 99999
4	Transaction Code	1	AN	32	32	N = New, R = Resubmit, V = Void, A = Adjustment
5	Record Type	1	AN	33	33	I = Inpatient, O = Outpatient, D = Drug, M = Miscellaneous
6	Receipt Date	8	N	34	41	CCYYMMDD; health plan receipt date of service
7	HAWI Client ID	10	AN	42	51	HAWI assigned client Identification number
8	Rendering Provider ID	8	AN	52	59	QUEST assigned provider Identification number
9	Referring Provider ID	8	AN	60	67	QUEST assigned provider Identification number
10	Location of Service	1	AN	68	68	Island/location code
11	Service Type	1	AN	69	69	M = Medical, D = Dental, B = Behavioral
12	Begin (From) Date	8	N	70	77	CCYYMMDD
13	Through (To) Date	8	N	78	85	CCYYMMDD
14	Diagnosis Code 1	6	AN	86	91	ICD-9-CM/DSM-4 code
15	Diagnosis Code 2	6	AN	92	97	ICD-9-CM/DSM-4 code
16	Diagnosis Code 3	6	AN	98	103	ICD-9-CM/DSM-4 code
17	Diagnosis Code 4	6	AN	104	109	ICD-9-CM/DSM-4 code
18	Place of Service	2	N	110	111	Place where service / procedure performed
19	HCPCS Code	5	AN	112	116	HCPCS code
20	Revenue Code	4	AN	117	120	Revenue code
21	NDC	11	AN	121	131	NDC code (pharmacy only)
22	Dental Code	5	AN	132	136	ADA/CDT-2 dental code (dental only)
23	Procedure Code Modifier	2	AN	137	138	CPT-4 or HCPCS modifiers
24	Tooth/Quadrant Identifier	2	AN	139	140	Tooth No (1-32, A-T) (dental only)
25	Tooth Surface Code 1	1	AN	141	141	ADA tooth surface code (dental only)
26	Tooth Surface Code 2	1	AN	142	142	ADA tooth surface code (dental only)
27	Tooth Surface Code 3	1	AN	143	143	ADA tooth surface code (dental only)
28	Tooth Surface Code 4	1	AN	144	144	ADA tooth surface code (dental only)

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

#	Data Name	Size	Type	Actual Position		Remarks
				From	To	
29	Tooth Surface Code 5	1	AN	145	145	ADA tooth surface code (dental only)
30	Quantity	5	N	146	150	99999
31	Days Supply	3	N	151	153	999
32	Provider Reimbursement Status	1	AN	154	154	C = Capitated, F = Fee for service, S = Staff
33	Billed Amount	8	N	155	162	999999V99; amount billed for this service
34	Reimbursement Amount	8	N	163	170	999999V99; amount reimbursed for this service
35	Copayment Amount	8	N	171	178	999999V99; copayment for this service
36	TPL Flag	1	AN	179	179	Y = Yes; N = No
37	Claims Status Reason Code	2	N	180	181	99
38	Filler	46	AN	182	227	Reserved for future use
39	HP Claim ID	20	AN	228	247	HP assigned claim ID
40	Original Encounter Record ID	20	AN	248	267	Encounter record ID from a previously submitted encounter

3.1.3 Encounter File Header Record

#	Data Name	Size	Type	Actual Position		Remarks
				From	To	
1	Health Plan ID	6	AN	1	6	QUEST assigned health plan Identifier
2	Current Date	8	N	7	14	YEARMMD – Creation date
3	File Type Code	2	AN	15	16	Type of encounters being submitted; EN = Encounter
4	Filler	251	AN	17	267	Reserved for future use

3.1.4 Encounter File Trailer Record

#	Data Name	Size	Type	Actual Position		Remarks
				From	To	
1	Trailer Indicator	6	AN	1	6	ZZZZZZ
2	Current Date	8	N	7	14	YEARMMD – Creation date
3	Total Count	6	N	15	20	Total number of records (including header and trailer records)
4	Filler	247	AN	21	267	Reserved for future use

3.2 Appendix 4B –Encounter Codes and Values

3.2.1 Claim Status Reason Codes

Code	Type	Description
01	DENIED	Patient not eligible
02	DENIED	Provider not eligible
03	DENIED	Ineligible Diagnosis
04	DENIED	No specialty referral by PCP
05	DENIED	Provider not a PCP
06	DENIED	Bill TPL
07	DENIED	Past filing deadline
08	DENIED	Duplicate claim
09	DENIED	TPL Paid
20	DENIED	Service/supply not a QUEST benefit
21	DENIED	Service/supply not a plan benefit
22	DENIED	Service/supply not a contracted benefit
23	DENIED	Service/supply exceeds maximum benefit
24	DENIED	Service/supply included in primary fee
25	DENIED	Provider ineligible for service/supply
26	DENIED	Provider capitated
27	DENIED	Patient ineligible for service/supply
28	DENIED	Procedure code not a HCPCS code
29	DENIED	Diagnosis not an ICD-9/DSM-4 code
30	DENIED	Formulary ineligible
31	DENIED	No prior authorization obtained
32	DENIED	Surgical assistant not required at resident hospital
33	DENIED	Sterilization/hysterectomy requirements not met
34	DENIED	Service/supply not medically necessary
35	DENIED	Plan unable to process claim as submitted
36	DENIED	Maximum allowance already paid
50	ADJUSTMENT	Copayment deducted from payment
51	ADJUSTMENT	Adjustment to claim previously paid
52	ADJUSTMENT	Adjustment to claim for duplicative service/supply
53	ADJUSTMENT	Additional payment to claim previously paid
54	ADJUSTMENT	Adjustment to claim to decrease payment
55	ADJUSTMENT	Adjustment to claim due to partial recovery by subrogation or TPL
70	VOID	Paid to wrong provider
71	VOID	Money recovered by subrogation or TPL
72	VOID	Delete original encounter, reprocessing in entirety
73	VOID	Paid To Wrong Member

3.2.2 Default Provider IDs

Code	Description
001011	Resident
001022	Emergency room physician
001033	Anesthesiologist
001044	Clinic Primary Care Provider
001055	Radiologist
001066	ECG Cardiologist in Emergency room setting
001077	Non-participating physician or facility who can not be identified by the plan
001088	Out of State provider
001099	Physical Therapist
001110	Occupational Therapist
001121	Speech pathologist/Audiologist
001132	Hearing aid technician
001143	Clinic staff
001154	Social Worker
001165	Substance Abuse Counselor
001176	Non-emergency transportation
001187	Translation services provider
001198	Meal Services (Added)
001209	Vision Services (Added)

3.2.3 Location Codes

Code	Description
A	Oahu
B	Maui
C	Molokai
D	Lanai
E	Kauai
F	Niihau
G	Hawaii
H	Left Blank For Future Use
I	Other state
J	Other country
Z	All islands

3.2.4 Provider Reimbursement Status Codes

Code	Description
C	Capitated
D	DRG
F	Fee For Service
N	Negotiated Rate
M	Monthly
O	Outlier
P	Per Diem
S	Staff

3.2.5 Z Codes

Code	Description
Z9000	EPSDT exam; Z9000-22 = catch-up immunizations
Z9001	Provider adjustment
Z9002	Medicare co-insurance
Z9004	Medicare paid
Z9005	HMO co-payment
Z9007	Additional payment
Z9008	Medicare deductible
Z9011	Total charge
Z9014	Third-party liability
Z9017	Gross adjustment
Z9019	Total service
Z9020	Tax
Z9060	QUEST enabling service, foreign language translation, per 15 minutes
Z9061	QUEST enabling service, non-compliance counseling per 15 minutes
Z9022	Patient's share
Z9300	Gingivectomy, osseous or mucogingival surgery, per tooth (<6 teeth)
Z9306	Alveolectomy (<6 teeth) per tooth
Z9309	Gingivectomy, per tooth (< 6 teeth)
Z9330	EPSDT, dental screening
Z9400	Lenses, single vision, per pair
Z9401	Lenses, bifocal, per pair
Z9408	Lens, single vision, per lens
Z9409	Lens, bifocal, per lens
Z9415	Nose pads
Z9416	Eyeglasses case
Z9440	Managed care EPSDT screening risk lead assessment SRLA
Z9499	Other ophthalmic material
Z9910	QUEST enabling service, ground transportation per mile (restricted to accessing needed health care services, and provided when no other appropriate means of transportation is available)

3.2.6 Revenue Codes

Code	Description
070	Medicare deductible
071	Medicare co-insurance
075	Other insurance
084	Additional payment
086	Miscellaneous service
087	Patient's share
088	Ineligible
089	Provider's adjustment
090	Equipment over XVII allow
091	State tax
092	Total allowable
093	Facility tax
094	Duplicate charge
095	Total service
096	Medicare ineligible

3.2.7 Place of Service Codes

Code	Description
TM	Telemedicine
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birth Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35	Adult Living Care Facility
41	Ambulance – Land
42	Ambulance – Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psych Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mental Retard
55	Residential Substance Abuse Treat Facil
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehab Facility
62	Comprehensive Outpatient Rehab Facility
65	ESRD Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

3.3 Appendix 4C – Encounter Error Reports

3.3.1 QUEST Encounter Pre-Syntax Error Report (EN000641)

#	Data Name	Size	Type	Actual Position		Remarks
				From	To	
1	Error Record Indicator	2	AN	1	2	Indicates error record; value ZZ
2	Encounter Record ID	20	AN	3	22	HP assigned unique encounter number
3	Encounter Detail No	5	N	23	27	HP assigned number uniquely identifying a record within the encounter
4	Filler	4	AN	28	31	Reserved for future use
5	Error Message	100	AN	32	131	Text specifying the error

3.3.2 QUEST Encounter Input Error Detail Report (EN000241)

#	Data Name	Size	Type	Actual Position		Remarks
				From	To	
1	Health Plan ID	6	AN	1	6	QUEST assigned health plan identifier
2	CRN	14	AN	7	20	Claim Reference Number
3	Encounter Record ID	20	AN	21	40	HP assigned unique encounter record number
4	HP Claim ID	20	AN	41	60	Health plan assigned identifier used to link to the health plan's internal system
5	Encounter Detail Number	5	N	61	65	HP assigned number uniquely identifying a record within the encounter
6	HAWI Client ID	10	AN	66	75	HAWI assigned client identification number
7	QUEST Error Code	4	AN	76	79	QUEST assigned error code
8	Field Identifier	3	AN	80	82	Identifies the field in the encounter where the error occurred
9	Error Message	86	AN	83	168	Description of the error

3.3.3 File Header Record Format (Encounter Error Reports 641/241)

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

3.3.4 File Trailer Record Format (Encounter Error Reports 641/241)

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

Hawaii PMMIS
Hawaii Prepaid Medical Management Information System
Health Plan Manual - Encounters

3.4.2 QUEST Hawaii Cycle Encounter Report (ECHAR947)

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

REPORT ID: ECHAR947		HAWAII CYCLE ENCOUNTER REPORT										PAGE: 1	
PROGRAM #: ECHAL947		AS OF 02/07/2003										RUN: 02/07/2003	
HEALTH PLAN ID: ANY HEALTH PLAN		ANYHEALTHPLAN - MEDICAL										18:06	
RUN DATE	FORM TYPE	ADJUDICATED ENCOUNTERS		PENDED ENCOUNTERS		HP DENIED & ADJUDICATED		HP VOIDED & ADJUDICATED		TOTAL ENCOUNTERS PROCESSED			
		#	%	#	%	#	%	#	%	#	%		
02/07/2003	HCFA 1500	0	.00	0	.00	0	.00	0	.00	0	.00		
	UB-92	0	.00	0	.00	0	.00	0	.00	0	.00		
	PHARMACY	0	.00	0	.00	0	.00	0	.00	0	.00		
	DENTAL	0	.00	0	.00	0	.00	0	.00	0	.00		
	TOTAL	0	.00	0	.00	0	.00	0	.00	0	.00		
001/04/2003	HCFA 1500	0	.00	0	.00	0	.00	0	.00	0	.00		
	UB-92	0	.00	0	.00	0	.00	0	.00	0	.00		
	PHARMACY	0	.00	0	.00	0	.00	0	.00	0	.00		
	DENTAL	0	.00	0	.00	0	.00	0	.00	0	.00		
	TOTAL	0	.00	0	.00	0	.00	0	.00	0	.00		
012/06/2002	HCFA 1500	0	.00	0	.00	0	.00	0	.00	0	.00		
	UB-92	0	.00	0	.00	0	.00	0	.00	0	.00		
	PHARMACY	0	.00	0	.00	0	.00	0	.00	0	.00		
	DENTAL	0	.00	0	.00	0	.00	0	.00	0	.00		
	TOTAL	0	.00	0	.00	0	.00	0	.00	0	.00		

Adjudicated Encounters

New encounters which were processed according to the policies and procedures of MQD and were determined to be valid.

Pended Encounters

New encounters which were processed according to the policies and procedures of MQD and did not pass the edits and audits processing.

HP Denied & Adjudicated

New encounters that had a Claim Status Reason Code (Denial Reason Code) that was > 0 and < 50, were processed successfully according to the policies and procedures of MQD, and were determined to be valid.

HP Voided & Adjudicated

New encounters that had a Claim Status Reason Code which was >= 70 & <= 73, were processed according to the policies and procedures of MQD, and were determined to be valid.

Total Encounters Processed

Total of the Adjudicated, Pended, HP Denied & Adjudicated and HP Voided & Adjudicated encounters.

3.5 Appendix 4D – Encounter Data Elements

3.5.1 HCP ID

Record Type:	Header [X]	Detail [X]		
Attributes:	ID [1 – HD]	Class [AN]	Length [6]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]
Field Definition:	Unique identifier of a participating health plan as assigned by Med-QUEST.			
Edit Rules/Criteria:	Must not be null. For table value, refer to section 3.7 Health Plan IDs.			

3.5.2 Encounter Record ID Number

Record Type:	Header [X]	Detail [X]		
Attributes:	ID [2 – HD]	Class [AN]	Length [20]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]
Field Definition:	Unique identifier for a specific encounter instance as assigned by the health plan.			
Edit Rules/Criteria:	Must not be null. To be assigned by the health plans.			

3.5.3 Encounter Detail Number

Record Type:	Header [X]	Detail [X]		
Attributes:	ID [3 – HD]	Class [AN]	Length [5]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]
Field Definition:	Unique identifier for an individual line number of the encounter instance as assigned by the health plan.			
Edit Rules/Criteria:	Must not be null. Must be numeric. If header, value equals 00000. If detail, value greater than 00000. To be assigned by the health plan.			

3.5.4 Transaction Code

Record Type:	Header[X]	Detail [X]			
Attributes:	ID [4 – HD]	Class [AN]	Length [1]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Identifier for the transaction type as assigned by the health plan to the submitted encounter record.				
Edit Rules/Criteria:	Must not be null. For table value, refer to section 3.1.1 QUEST Encounter Header Input Record. Refer to section 2.1.2 Encounter Definitions for more information.				

3.5.5 Record Type

Record Type:	Header[X]	Detail [X]			
Attributes:	ID [5 – HD]	Class [AN]	Length [1]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Identifier for the type of encounter record as assigned by the health plan.				
Edit Rules/Criteria:	Must not be null. Must be a valid value. For table value, refer to section 3.1.1 QUEST Encounter Header Input Record.				

3.5.6 Receipt Date

Record Type:	Header[X]	Detail [X]			
Attributes:	ID [6 – HD]	Class [N]	Length [8]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Date in which service record was captured by the health plan, or the date in which the servicing provider submitted the service record to the health plan, whichever is earlier.				
Edit Rules/Criteria:	Must not be null. Must be a valid date in format CCYYMMDD. Must be greater than or equal to birth date. Must be greater than or equal to service date. Must be less than or equal to current date. Must be greater than or equal to 19940801.				

3.5.7 HAWI Client ID

Record Type:	Header[X]	Detail [X]	
Attributes:	ID [7 – HD]	Class [AN]	Length [10]
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y] Drug [Y]
Field Definition:	Identifier that uniquely identifies the eligible recipient and is assigned by the HAWI Eligibility System.		
Edit Rules/Criteria:	Must not be null. Must be a valid HAWI assigned ID. If no ID available, use conventions identified for 'Letter People' and newborns. For more information, refer to sections 2.4.6, Reporting Encounters Using Default Provider Information, and 2.4.7, Required Data Elements.		

3.5.8 HCP Claim ID

Record Type:	Header[X]	Detail [X]	
Attributes:	ID [41H – 39D]	Class [AN]	Length [20]
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y] Drug [Y]
Field Definition:	Internal health plan identification number used to link the encounter record to the plan's internal record. This is also the encounter tracer number.		
Edit Rules/Criteria:	Must not be null. To be assigned by the health plan.		

3.5.9 Original Encounter Record ID Number

Record Type:	Header[X]	Detail [X]	
Attributes:	ID [42H – 40D]	Class [AN]	Length [20]
Required for Record Type:	Inpatient [C]	Outpatient [C]	Misc [C] Drug [C]
Field Definition:	Previously submitted Encounter Record ID Number used to link present encounter to the antecedent encounter. Link is required to initiate void (V), adjustment (A), or resubmit (R) transactions.		
Edit Rules/Criteria:	Must be a valid value. If encounter transaction type is N, set to null. If encounter transaction type is V, A, or R, must not be null.		

3.5.10 Quest Billing Provider ID Number

Record Type:	Header[X]	Detail []			
Attributes:	ID [8 – H]	Class [AN]	Length [8]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	QUEST–assigned identification number of the entity submitting the record of service(s) to the health plan for reimbursement or record keeping.				
Edit Rules/Criteria:	Must not be null. Must be a valid QUEST ID Number. Must be right justified. Padded with leading zeros.				

3.5.11 Birth Date

Record Type:	Header[X]	Detail []			
Attributes:	ID [9 – H]	Class [N]	Length [8]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Date of birth of the recipient as assigned by the HAWI eligibility system. If date of birth is not reported as part of the eligibility information received from Med-QUEST ('Letter People' and Newborns), default to the date of birth reported by the provider.				
Edit Rules/Criteria:	Must not be null. Must be a valid date in format CCYYMMDD. Must be less than current date.				

3.5.12 Gender

Record Type:	Header[X]	Detail []			
Attributes:	ID [10 – H]	Class [AN]	Length [1]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Gender of the recipient as reported by the HAWI eligibility system. If gender is not reported as part of the eligibility information received from Med-QUEST ('Letter People' and Newborns), default to the gender reported by the provider.				
Edit Rules/Criteria:	Must not be null. Values are M (male) or F (female).				

3.5.13 Patient Status

Record Type:	Header[X]	Detail []			
Attributes:	ID [11 – H]	Class [AN]	Length [2]		
Required for Record Type:	Inpatient [Y]	Outpatient []	Misc []	Drug []	
Field Definition:	Indicates the patient's status as of the Encounter Covers Through date of this encounter.				
Edit Rules/Criteria:	Must be a valid patient status code If record type is inpatient, must not be null.				

3.5.14 Primary Diagnosis Code

Record Type:	Header[X]	Detail []			
Attributes:	ID [12 – H]	Class [AN]	Length [6]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Principal diagnosis code of the patient's condition. Defined to be the Prim Diag Cd (Primary Diagnostic Code) on a UB–92 and the first diagnosis code on a HCFA–1500. Default diagnosis 799.9 can only be reported for non–emergency transportation, translation, drug, and meals/lodging service encounters. Default diagnosis 525 can only be reported for dental service encounters.				
Edit Rules/Criteria:	Must not be null. Must be a valid ICD-9 or DSM-4 in format displayed below. Left justified. Decimal implied. Leading zeros. Examples: E800 E 8 0 0 V09.90 V 0 9 9 0 001.0 0 0 1 0				

3.5.15 Date Of Onset

Record Type:	Header[X]	Detail []			
Attributes:	ID [13 – H]	Class [N]	Length [8]		
Required for Record Type:	Inpatient []	Outpatient []	Misc [C]	Drug []	
Field Definition:	The date of the initial diagnosis for which services are being provided for all pregnancy related encounters. It is the date of the last menstrual period (LMP). For accident related encounters, it is the date of the accident.				
Edit Rules/Criteria:	Must be a valid date in format CCYYMMDD. Must be greater than or equal to birth date. Must be less than or equal to service date. If not required, set to null.				

3.5.16 Total Billed Amount

Record Type:	Header[X]	Detail []			
Attributes:	ID [14 – H]	Class [N]	Length [8]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Total dollar amount billed to health plans by servicing providers as the sum of all of the detail records associated with this encounter header.				
Edit Rules/Criteria:	Must not be null. Must be numeric. Must be greater than or equal to 0. Must be a valid format 999999V99.				

3.5.17 Total Reimbursed Amount

Record Type:	Header[X]	Detail []			
Attributes:	ID [15 – H]	Class [N]	Length [8]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Total dollar amount paid by the health plans to the servicing providers as the sum of all of the detail records associated with this encounter header.				
Edit Rules/Criteria:	Must not be null. Must be numeric. Must be greater than or equal to 0. Must be a valid format 999999V99.				

3.5.18 Total Copayment Amount

Record Type:	Header[X]	Detail []			
Attributes:	ID [16 – H]	Class [N]	Length [8]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Total dollar amount paid by the recipient for the sum of all of the detail records associated with this encounter header.				
Edit Rules/Criteria:	Must not be null. Must be numeric. Must be greater than or equal to 0. Must be a valid format 999999V99.				

3.5.19 Total TPL Amount

Record Type:	Header[X]	Detail []			
Attributes:	ID [17 – H]	Class [N]	Length [8]		
Required for Record Type:	Inpatient [C]	Outpatient [C]	Misc [C]	Drug [C]	
Field Definition:	Total amount received toward the payment of the service(s) reported on the entire encounter from another payer.				
Edit Rules/Criteria:	Must be numeric. Must be a valid format 999999V99. If present, must be greater than or equal to 0. If TPL flag is Y, must not be null.				

3.5.20 Type Of Admission

Record Type:	Header[X]	Detail []			
Attributes:	ID [18 – H]	Class [AN]	Length [1]		
Required for Record Type:	Inpatient [Y]	Outpatient []	Misc []	Drug []	
Field Definition:	Type of admission for an inpatient stay.				
Edit Rules/Criteria:	Must be a valid value. If record type is I, must not be null.				

3.5.21 Encounter Covers From Date

Record Type:	Header[X]	Detail []			
Attributes:	ID [19 – H]	Class [N]	Length [8]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc []	Drug []	
Field Definition:	Beginning service date for the reporting period that spans the entire encounter.				
Edit Rules/Criteria:	Must be a valid date in format CCYYMMDD. Must be greater than or equal to birth date. Must be less than or equal to service date. If record type is I or O, must not be null.				

3.5.22 Encounter Covers Through Date

Record Type:	Header[X]	Detail []	
Attributes:	ID [20 – H]	Class [N]	Length [8]
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [] Drug []
Field Definition:	Ending service date for the reporting period that spans the entire encounter.		
Edit Rules/Criteria:	Must be a valid date in format CCYYMMDD. Must be greater than or equal to birth date. Must be less than or equal to service date. If record type is I or O, must not be null.		

3.5.23 Inpatient Admission Date

Record Type:	Header[X]	Detail []	
Attributes:	ID [21 – H]	Class [N]	Length [8]
Required for Record Type:	Inpatient [Y]	Outpatient [C]	Misc [] Drug []
Field Definition:	Date the recipient was admitted to an inpatient facility. Effective date of election of hospice benefits. Start date of home health services.		
Edit Rules/Criteria:	Must be a valid date in format CCYYMMDD. Must be greater than or equal to birth date. Must be less than or equal to service date. If record type is I, must not be null.		

3.5.24 Inpatient Discharge Date

Record Type:	Header[X]	Detail []	
Attributes:	ID [22 – H]	Class [N]	Length [8]
Required for Record Type:	Inpatient [C]	Outpatient []	Misc [] Drug []
Field Definition:	Date the recipient was discharged from an inpatient facility. Not required for interim inpatient encounters.		
Edit Rules/Criteria:	Must be a valid date in format CCYYMMDD. Must be greater than or equal to birth date. Must be less than or equal to service date. If not required, set to null. If patient not discharged, set to null.		

3.5.25 Type Of Facility

Record Type:	Header[X]	Detail []		
Attributes:	ID [23 – H]	Class [N]	Length [1]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc []	Drug []
Field Definition:	Classification code for the type of facility where services were rendered. It is the first position of the Type of Bill.			
Edit Rules/Criteria:	Must be a valid value If record type is I or O, must not be null.			

3.5.26 Bill Classification

Record Type:	Header[X]	Detail []		
Attributes:	ID [24 – H]	Class [N]	Length [1]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc []	Drug []
Field Definition:	Classification code for the type of facility setting where services were rendered. It is the second position of the Type of Bill. (Use standard, commercially available, UB-92 coding).			
Edit Rules/Criteria:	Must be a valid value If record type is I or O, must not be null.			

3.5.27 Frequency

Record Type:	Header[X]	Detail []		
Attributes:	ID [25 – H]	Class [N]	Length [1]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc []	Drug []
Field Definition:	Frequency of the claim being submitted. It is the third position of the Type of Bill.			
Edit Rules/Criteria:	Must be a valid value. If record type is I or O, must not be null.			

3.5.28 Covered Days

Record Type:	Header[X]	Detail []		
Attributes:	ID [26 – H]	Class [N]	Length [3]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc []	Drug []
Field Definition:	Number of days authorized for an inpatient stay.			
Edit Rules/Criteria:	Must be numeric. If record type is I or O, must not be null.			

3.5.29 Other Diagnosis Codes

Record Type:	Header[X]	Detail []			
Attributes:	ID [27 – 34 H]	Class [AN]	Length [6]		
Required for Record Type:	Inpatient [C]	Outpatient [C]	Misc [C]	Drug [C]	
Field Definition:	Related to additional diagnosis for which patient is being treated. Up to eight additional (other) diagnosis codes for record types I and O. Up to four additional (other) diagnosis codes for record type M.				
Edit Rules/Criteria:	Must not be null. Must be a valid ICD-9 or DSM-4 in format displayed below. Left justified. Decimal implied. Leading zeros. Examples: E800 E 8 0 0 V09.90 V 0 9 9 0 001.0 0 0 1 0				

3.5.30 Principal ICD-9 Procedure Code

Record Type:	Header[X]	Detail []			
Attributes:	ID [35 – H]	Class [N]	Length [4]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc []	Drug []	
Field Definition:	Procedure code of the service performed as part of the encounter that is most closely related to the principal diagnosis.				
Edit Rules/Criteria:	Must be a valid ICD-9 CM value. If record type is I or O, must not be null. Decimal is implied. Left justify.				

3.5.31 Other ICD-9 Procedure Codes

Record Type:	Header[X]	Detail []			
Attributes:	ID [36 – 40 H]	Class [N]	Length [4]		
Required for Record Type:	Inpatient [C]	Outpatient [C]	Misc []	Drug []	
Field Definition:	Procedure code, which identifies any significant procedure, performed other than the principal procedure.				
Edit Rules/Criteria:	Must be a valid ICD-9 CM value. Decimal is implied. Left justify.				

3.5.32 Rendering Provider ID Number

Record Type:	Header[]	Detail [X]	
Attributes:	ID [8 – D]	Class [AN]	Length [8]
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y] Drug [Y]
Field Definition:	QUEST assigned identification number of the provider rendering services. QUEST assigned default provider identification numbers may be used when appropriate.		
Edit Rules/Criteria:	<p>Must be a valid QUEST ID Number or Default QUEST Provider ID. Must be right justified. Padded with leading zeros. Refer to sections 2.4.6, Reporting Encounters Using Default Provider Information, 2.4.7, Required Data Elements, and 3.2, Appendix 4B –Encounter Codes and Values, for more information.</p>		

3.5.33 Referring/Attending/Prescribing Provider ID

Record Type:	Header[]	Detail [X]	
Attributes:	ID [9 – D]	Class [AN]	Length [8]
Required for Record Type:	Inpatient [Y]	Outpatient [C]	Misc [C] Drug [Y]
Field Definition:	QUEST assigned identification number of the Referring, Attending, or Prescribing Physician. Required for all laboratory, radiology, DME, consultative (specialists), podiatry, and rehabilitative services. QUEST assigned default provider identification numbers may be used when appropriate.		
Edit Rules/Criteria:	<p>Must be a valid QUEST ID Number or Default QUEST Provider ID. Must be right justified. Padded with leading zeros. Refer to sections 2.4.6, Reporting Encounters Using Default Provider Information, 2.4.7, Required Data Elements, and 3.2, Appendix 4B –Encounter Codes and Values, for more information.</p>		

3.5.34 Location Of Service

Record Type:	Header[]	Detail [X]			
Attributes:	ID [10 – D]	Class [AN]	Length [1]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Geographical location where services were rendered. If a provider travels from his or her usual servicing island to another island, the destination island should be used.				
Edit Rules/Criteria:	Table value, refer to 3.2, Appendix 4B –Encounter Codes and Values. Must not be null.				
Note:	When submitting encounter records, Provider Type “01” Group Provider ID numbers cannot be used as a Rendering Provider ID. If this occurs, the Group Provider ID will “error” as well as the Location of Service. Once the Rendering Provider ID has been entered correctly the Location of Service “error” will be automatically corrected.				

3.5.35 Service Type

Record Type:	Header[]	Detail [X]			
Attributes:	ID [11 – D]	Class [AN]	Length [1]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Should reflect the contracted plan type.				
Edit Rules/Criteria:	Must not be null. Table value may be M = Medical, D = Dental, or B = Behavioral.				

3.5.36 Begin (From) Date

Record Type:	Header[]	Detail [X]			
Attributes:	ID [12 – D]	Class [N]	Length [8]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Begin date on which the service was provided to the recipient.				
Edit Rules/Criteria:	Must not be null. Must be a valid date format CCYYMMDD. Must be greater than or equal to Birth Date. Must be greater than or equal to 19940801. Must be less than or equal to Submission Date.				

3.5.37 Through (To) Date

Record Type:	Header[]	Detail [X]			
Attributes:	ID [13 – D]	Class [N]	Length [8]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	End date of a series of services provided to the recipient. If the service does not exceed a day, and the Begin (From) Date and the Through (To) Date are the same, the date must be populated in both fields.				
Edit Rules/Criteria:	Must not be null. Must be a valid date format CCYYMMDD. Must be greater than or equal to Birth Date. Must be greater than or equal to 19940801. Must be less than or equal to Submission Date. Must be greater than or equal to Begin Date.				

3.5.38 Diagnosis Code 1

Record Type:	Header[]	Detail [X]			
Attributes:	ID [14 – D]	Class [AN]	Length [6]		
Required for Record Type:	Inpatient []	Outpatient []	Misc [Y]	Drug [Y]	
Field Definition:	Diagnosis code of the condition relating to the service reported on the detail record. Default diagnosis 799.9 can only be reported for non-emergency transportation, translation, drug, and meals/lodging service encounters. Default diagnosis 525 can only be reported for dental service encounters.				
Edit Rules/Criteria:	Must be a valid value. Must be a valid ICD-9 or DSM-4 in format displayed below. Left justified. Decimal implied. Leading zeros. Examples: E800 E 8 0 0 V09.90 V 0 9 9 0 001.0 0 0 1 0				

3.5.39 Other Diagnosis Codes

Record Type:	Header[]	Detail [X]		
Attributes:	ID [15 – 17 D]	Class [AN]	Length [6]	
Required for Record Type:	Inpatient []	Outpatient []	Misc [C]	Drug [C]
Field Definition:	Related to additional diagnoses for which the recipient is being treated. Default diagnosis 799.9 can only be reported for non-emergency transportation, translation, drug, and meals/lodging service encounters. Default diagnosis 525 can only be reported for dental service encounters.			
Edit Rules/Criteria:	<p>Must be a valid value. Must be a valid ICD-9 or DSM-4 in format displayed below. Left justified. Decimal implied. Leading zeros. Examples: E800 E 8 0 0 V09.90 V 0 9 9 0 001.0 0 0 1 0 </p>			

3.5.40 Place Of Service

Record Type:	Header[]	Detail [X]		
Attributes:	ID [18 – D]	Class [N]	Length [2]	
Required for Record Type:	Inpatient []	Outpatient []	Misc [Y]	Drug []
Field Definition:	Site where the recipient received the service reported on the detail record.			
Edit Rules/Criteria:	Table value, refer to section 3.2.7 Place of Service Codes. If not required, set to null.			

3.5.41 HCPCS Code

Record Type:	Header[]	Detail [X]		
Attributes:	ID [19 – D]	Class [AN]	Length [5]	
Required for Record Type:	Inpatient []	Outpatient [C*]	Misc [C**]	Drug []
Field Definition:	Specific procedure code (CPT-4, HCFA alphanumeric, local payer) related to the service performed for the recipient.			
Edit Rules/Criteria:	<p>Must be a valid value. Must be valid for the date of service. If not required, set to null.</p>			
Note:	<p>* Used in conjunction with certain revenue codes ** Not applicable for dental services</p>			

3.5.42 Revenue Code

Record Type:	Header[]	Detail [X]		
Attributes:	ID [20 – D]	Class [AN]	Length [4]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc []	Drug []
Field Definition:	Code, which identifies a specific accommodation, ancillary, or billing calculation. Revenue codes are to be reported to allow for identification of services provided. Certain outpatient revenue codes require an accompanying HCPCS code. HCPCS codes should be reported on the same detail record as the revenue code.			
Edit Rules/Criteria:	<p>Must be a valid value.</p> <p>Must have a corresponding HCPCS code for LTC and waitlisted ancillary services, and other outpatient services.</p> <p>If Record Type = I or O, must not be null.</p> <p>Must submit 4 digits even though Rev Code may only be 3 digits.</p> <p>If submitting a 3 digit Rev Code, first digit must be a space or zero.</p> <p>If not required, set to null.</p>			

3.5.43 NDC Code

Record Type:	Header[]	Detail [X]		
Attributes:	ID [21 – D]	Class [AN]	Length [11]	
Required for Record Type:	Inpatient []	Outpatient []	Misc []	Drug [Y]
Field Definition:	Specific code relating to the identification of a prescription drug dispensed to a recipient. Drugs provided in the physician's office must be reported by HCPCS. All drugs dispensed through a pharmacy must have an associated NDC code.			
Edit Rules/Criteria:	<p>If Record Type = D, must not be null.</p> <p>Must be a valid value.</p> <p>Must be valid for the date of service.</p> <p>If not required, set to null.</p>			

3.5.44 Dental Code

Record Type:	Header[]	Detail [X]		
Attributes:	ID [22 – D]	Class [AN]	Length [5]	
Required for Record Type:	Inpatient []	Outpatient []	Misc [C]	Drug []
Field Definition:	Specific code related to the dental service performed for the recipient. Required for Service Type D.			
Edit Rules/Criteria:	<p>Must be a valid value.</p> <p>Must be valid for the date of service.</p> <p>If Service Type = D, must not be null.</p> <p>If not required, set to null.</p> <p>Must have a corresponding Tooth Surface and or Tooth Number/Quadrant identifier for specific services.</p>			

3.5.45 Procedure Code Modifier

Record Type:	Header[]	Detail [X]			
Attributes:	ID [23 – D]	Class [AN]	Length [2]		
Required for Record Type:	Inpatient []	Outpatient [C]	Misc [C]	Drug []	
Field Definition:	Service code modifier provides additional information about the nature of the service performed.				
Edit Rules/Criteria:	Must be a valid value. If not required, set to null.				

3.5.46 Tooth/Quadrant Identifier

Record Type:	Header[]	Detail [X]			
Attributes:	ID [24 – D]	Class [AN]	Length [2]		
Required for Record Type:	Inpatient []	Outpatient []	Misc [C]	Drug []	
Field Definition:	Specific tooth or quadrant on which the service was performed. Required for specific CDT-2 codes for dental procedures.				
Edit Rules/Criteria:	Must be a valid value If not required, set to null.				

3.5.47 Tooth Surface Codes

Record Type:	Header[]	Detail [X]			
Attributes:	ID [25 – 29 D]	Class [AN]	Length [1]		
Required for Record Type:	Inpatient []	Outpatient []	Misc [C]	Drug []	
Field Definition:	The applicable tooth surface on which the service was performed. Required for specific CDT-2 codes for dental procedures.				
Edit Rules/Criteria:	Must be a valid value. If not required, set to null.				

3.5.48 Quantity

Record Type:	Header[]	Detail [X]		
Attributes:	ID [30 – D]	Class [N]	Length [5]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]
Field Definition:	Value relates to the quantity or units of service provided to the recipient. Units for pharmacy are to be reported as the number of pills/tablets dispensed or The NCPDP guidelines for reporting injectable/liquids. Units for DME/Supplies are to be reported using the current Medicare standards. Anesthesia units are to reflect the actual minutes used in delivering anesthesia.			
Edit Rules/Criteria:	Must not be null. Must be numeric. Right justify.			

3.5.49 Days Supply

Record Type:	Header[]	Detail [X]		
Attributes:	ID [32 – D]	Class [N]	Length [3]	
Required for Record Type:	Inpatient []	Outpatient []	Misc []	Drug [Y]
Field Definition:	Number of days for which the prescription was dispensed.			
Edit Rules/Criteria:	Must be a valid value. If Record Type = D, must not be null. If not required, set to null. Right justify.			

3.5.50 Provider Reimbursement Status

Record Type:	Header[]	Detail [X]		
Attributes:	ID [32 – D]	Class [AN]	Length [1]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]
Field Definition:	Reimbursement arrangement between the health plan and the servicing provider as defined by the health plan.			
Edit Rules/Criteria:	Must not be null. Must be a valid value, refer to section 3.2.4 Provider Reimbursement Status Codes.			

3.5.51 Billed Amount

Record Type:	Header[]	Detail [X]		
Attributes:	ID [33 – D]	Class [N]	Length [8]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]
Field Definition:	Dollar amount billed to the health plan by the provider for the specific services indicated in this detail record.			
Edit Rules/Criteria:	Must be numeric. Must be greater than or equal to 0. Must be a valid format 999999V99.			

3.5.52 Reimbursed Amount

Record Type:	Header[]	Detail [X]		
Attributes:	ID [34 – D]	Class [N]	Length [8]	
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]
Field Definition:	Dollar amount paid to the provider by the health plan for the specific service indicated in this detail record.			
Edit Rules/Criteria:	Must be numeric. Must be greater than or equal to 0. Must be a valid format 999999V99.			

3.5.53 Copayment Amount

Record Type:	Header[]	Detail [X]		
Attributes:	ID [35 – D]	Class [N]	Length [8]	
Required for Record Type:	Inpatient [C]	Outpatient [C]	Misc [C]	Drug [C]
Field Definition:	Dollar amount paid by the recipient for the service specified on this detail record.			
Edit Rules/Criteria:	Must be numeric. Must be greater than or equal to 0. Must be a valid format 999999V99.			

3.5.54 TPL Flag

Record Type:	Header[]	Detail [X]			
Attributes:	ID [36 – D]	Class [AN]	Length [1]		
Required for Record Type:	Inpatient [Y]	Outpatient [Y]	Misc [Y]	Drug [Y]	
Field Definition:	Indicates if a recipient has third party coverage applicable for the service provided as identified by the health plans.				
Edit Rules/Criteria:	Must not be null. Must be a valid value. Data Values: Code Y = Type Yes and Code N = Type No				

3.5.55 Claims Status Reason Code

Record Type:	Header[]	Detail [X]			
Attributes:	ID [37 – D]	Class [N]	Length [2]		
Required for Record Type:	Inpatient [C]	Outpatient [C]	Misc [C]	Drug [C]	
Field Definition:	Reason that the service was denied, adjusted, or voided by the health plan.				
Edit Rules/Criteria:	Must be a valid value, refer to section 3.2.1 Claim Status Reason Codes. If not required, set to null.				

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

3.6.1 Overview

The MQD FTP file server is the source of all file transfers between the MQD and the health plans. Specific technical specifications and instructions will be provided directly to each health plan's technical contact. This section contains basic information regarding the MQD FTP file server.

3.6.2 Virtual Private Network (VPN)

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

To obtain the client software and login information, health plans should contact the MQD Systems Office Network Coordinator.

3.6.3 Availability

The FTP file server is available 24 hours a day, seven days a week. A calendar with the dates when files should be submitted and will be available to the health plans will be provided quarterly in a QUEST health plan memo and/or email. Information regarding routine maintenance will be included in this memo and/or email.

3.6.4 Login

The health plan user ID (login name) will be the six-character Health Plan ID that has been assigned to each health plan for HPMMIS. A password will be assigned to the health plans and verbally communicated to the health plan's technical contact. Additional technical specifications (IP address, etc.) will be provided directly to the health plan's technical contact.

3.6.5 Filenames

Filenames will follow the 10.3 standard with alphanumeric characters. Each health plan has been assigned a two-character health plan identifier for the purpose of naming files. The plan identifiers are:

Aloha Care Medical	AM
Aloha Care Dental	AD
Queen’s Hawaii Care	QM
HMSA Medical	HM
HMSA Dental	HD
HMSA Behavioral Health	HB
Kaiser	KM
Straub	SM
Kapiolani HealthHawaii	PM
DentiCare	DD
Department of Health, CAMHD	CB
Department of Health, Early Intervention Programs	EB
Med-QUEST Division Files (Provider Master Registry)	MQ
Cyrca Insurance Management	TP
Community Care Management, Corp	CC
Family Dental Clinics	D1
Harold H. Masunaga, DDS, Inc	D2
Ohana Dental Center	D3
PACE	PC

3.6.6 Encounter Filenames

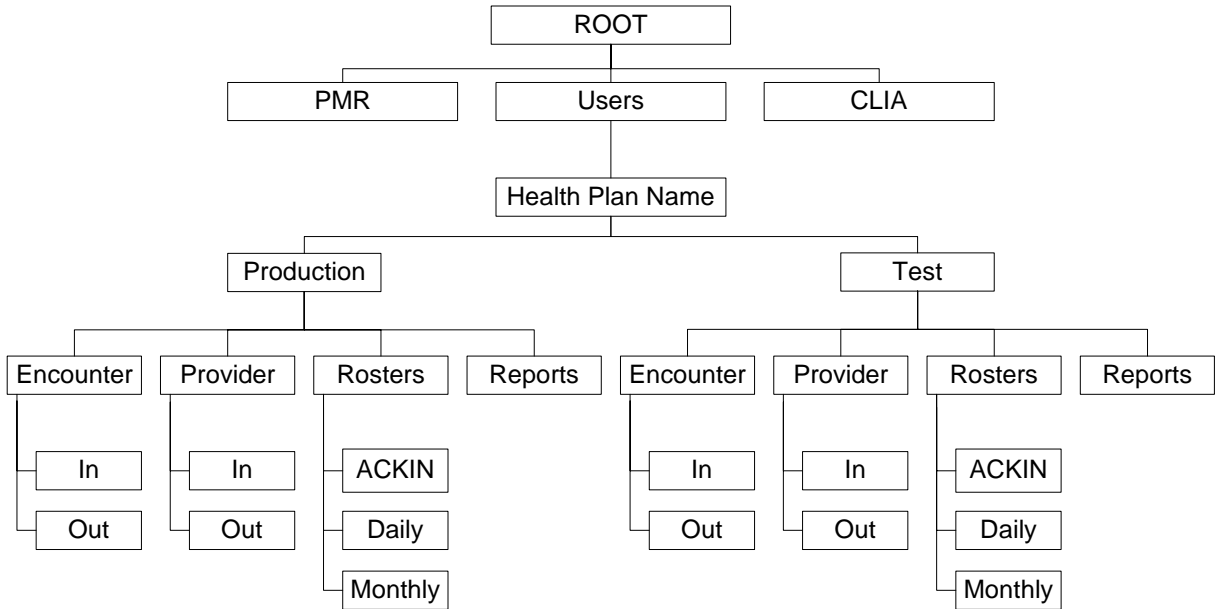
Files will be sent and received by health plans using the naming conventions listed in the table below. Filenames will be 10.3 where the first two characters identify the health plan; characters 3 – 6 the year; characters 7 and 8 the month; characters 9 and 10 the day the submission is due to the MQD FTP Server. The extensions to these files are listed in a separate table below depending on whether the file is encounter, provider or recipient related.

Submissions>Returns	Filename	Extension
Encounter submittals	XXYYYYMMDD	.ENC
Encounter Error Report (241)	XXYYYYMMDD	.241
Encounter Error Report (641)	XXYYYYMMDD	.261
Hawaii Cycle Encounter Report	XXYYYYMMDD	.947
Duplicate ERI by Error Code	XXYYYYMMDD	.179

3.6.7 Directory Structure

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

MQD FTP Directory Structure



3.6.8 Production Folder

Day to day activities with the health plans will be in the production area of the FTP fileserver. Data files placed/retrieved from the production folders will be processed by HPMMIS and should be processed by the health plans to meet their contractual obligations.

3.6.9 Test Folder

After HPMMIS is implemented, any future file transfer testing on the FTP server will be conducted in the test area. The test area will be used for testing changes that the MQD or health plan may need.

3.6.10 Production and Test Subfolders

3.6.10.1 Encounter

All encounter-related files will be included under the Encounter folder in one of two subfolders. The two subfolders are: In and Out. The In folder is where each health plan will place its monthly encounter submissions. The Out folder is where each health plan will pick-up its error reports and files from the MQD.

3.6.10.2 Reports

The Reports folder will currently contain the Hawaii Cycle Encounter Report (ECHAR947) and the Duplicate ERI by Error Code report (ECHAR179). They will be available for pick up by the Health Plans at the same time as the .241 file. Although the Reports folder's use has not been finalized, it is anticipated that the health plans will also be able to utilize this folder to submit reports, such as HEDIS.

3.7 Health Plan IDs

Plan Code	Description
ALOHAC	Alohacare - Medical
HMSAAA	HMSA - Medical
KAISER	Kaiser - Medical
KAPIOL	Kapiolani - Medical
QUEENS	Queen's - Medical
STRAUB	Straub - Medical
TRANSP	Transplant Plan
ALOHAD	Alohacare – Dental
DEN001	Family Dental Clinics
DEN002	Harold H. Masunaga, DDS, Inc
DEN003	Ohana Dental Center
DENTIC	Denticare – Dental
HMSADE	HMSA – Dental
CAMHDA	CAMHD
DOHEIP	DOH Early Intervention Program
HMSABH	HMSA Behavioral Health
ANYFFS	Fee-For-Service
EMGSVC	Fee-For-Service Emergency Only
NONPAY	Non-Pay
PACEHP	PACE Medical/PACE Dental
PRISON	Public Safety Division
QMBONY	QMB – No Payment Permitted
QNAFFS	QUEST-Net Adults FFS Medical & Dental
YOUTHS	Office of Youth Services
CYRCAT	CYRCA Insurance Management
CCMCCC	Community Care Management, Corp.

4 Contacts

4.1 Systems Office

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

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

If your problem is critical to your operation, please call the above personnel.

For calls reaching Systems Office Staff voicemail, a customer can leave a message or press "03" and the call will be transferred to the MQD Help Desk for assignment. If you get the Help Desk voicemail, please leave a message and a SO staff member will return your call within 2 hours (during normal business hours).

5 Addendums to Health Plan Manual – Encounter

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