

The Forum Companion Document
For use with ANSI ASC X12N
Health Care Services Review - Request for Review & Response
Implementation Guide

Health Care Service Review – Request for Review and Response

278

ANSI ASC X12N 278 (004010X094A1)

***** DRAFT *** Version:
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NOTE TO READER

The HIPAA designated X.12 committee drafted the Health Care Services Review - Request for Review & Response transaction (278) with the intention that it address an extremely broad set of business scenarios. These scenarios include, but are not limited to, Referrals, Notifications, Authorizations, Certifications and Benefit Advisories. Health plans and providers across the healthcare community reviewed the initial version of the 278 transaction (004010X094). Their response highlighted numerous “real world” information exchanges that either were not addressed with the transaction or needed some level of refinement/clarification in order to be implemented. In February 2003, an updated version of the 278 transaction (004010X094A1) was approved to replace the original version.

The Forum’s 278 task force has reviewed the 004010X094A1 version of the 278 transaction and has drafted a preliminary Companion Document for it. The task force recommends that more extensive implementation experience be gathered before publishing the detail implementation sections of the Companion Document. More experience will allow individual members of the task force to gain increased understanding and confidence in . . .

- The extent to which the new version of the transaction is able to adequately and appropriately address the full range of typical business scenario
- How the transaction should be implemented in order to completely and accurately convey the information associated with each scenario in a compliant manner.

When the task force meets in the next phase of this initiative, its members will have more knowledge and experience upon which to propose and agree upon conventions for implementing the 278 transaction.

In the mean time, the preliminary draft of the Prologue section follows and the detail implementation sections are available from any of the participating health plans. (Contact information for these health plans can be found at www.wahealthcareforum.org/hipaa/rollout/HP_readiness.asp)

Before beginning any implementation efforts, the health plans encourage their trading partners to contact them for the detail implementation sections of the 278 Companion Document. At that time, discussion can begin about . . .

- which business scenario are part of the health plan’s business practices (not all scenarios are applicable to the business practices of all health plans.)
- conventions for implementing the health plan’s specific business scenarios.

Introduction

Washington Healthcare Forum Services (The Forum) is a state-wide consortium of health care payer and provider organizations in the Pacific Northwest region. The Forum focuses its efforts on simplifying administrative processes between health plans, hospitals and medical groups.

An electronic version of this and other companion documents can be found at www.wahealthcareforum.org. From the home page, the path is HIPAA Services, Work Products, Companion Documents.

For additional information about The Forum see www.wahealthcareforum.org.

Objective of Companion Document

The Forum is publishing this Implementation Guide Companion to accompany the ASC X12N implementation guide for the ASC X12 Health Care Service Review-Request for Response (278) Transaction.

The primary purpose of the guide companion is to document understandings, assumptions and conventions agreed upon by commercial health plans in Washington State in order to minimize possible variability in how the transaction may be interpreted and implemented. Minimizing variability should help to reduce time and cost investments that all healthcare organizations, providers as well as health plans, need to make in order to implement this transaction. Health plans participating in this initiative include First Choice Health Plan, Group Health Cooperative, Premera Blue Cross and Regence BlueShield.

This document does not mandate the format or content of the transaction that is exchanged between trading partners. Health plans will process any transaction received from a provider organization, or their intermediary, that is compliant with the Implementation Guide. This Companion Document is intended to convey information that *may* make it easier for provider organizations to a) implement a compliant transaction and b) understand responses from health plans about a submitted transaction.

The Companion Document was developed to guide organizations through the implementation process so that the resulting transaction will meet the following business objectives:

1. *Convey all required business information:* The transaction will convey the comprehensive set of information that is required for health plans to conduct their business.

2. *Interpret information in the same way:* The definition of the transaction will be specific so that trading partners can correctly interpret, from a business perspective, the information that is received from each other.
3. *Simplify the communication:* The transaction will be standard to simplify communication between trading partners and to comply with HIPAA regulation.

Intended Use as Part of Trading Partner Agreements

This Companion Document is likely to be a part of any *trading partner agreement* between a health plan and an electronic trading partner, such as an intermediary, a hospital, a physician group, etc. The term '*trading partner agreement*' is used to refer to a verbal or documented understanding between organizations. It is not intended to imply any type of contractual commitment. Organizations may refer to this documented understanding by other names.

Trading partners will be encouraged to follow the Conventions and Codes outlined in this Companion Document. These conventions are suggestions and not mandates. Adherence to these Conventions and Codes will be assumed unless otherwise stated and specifically described in the *trading partner agreement*.

Trading partners should review these conventions before implementing the transaction and should agree on which ones will be followed. These conventions provide a focused starting point for trading partner discussions. Trading partner discussions may lead to modifying, deleting and/or adding conventions. Any and all modifications should comply with the HIPAA Implementation Guide. All conventions should be clearly stated in *trading partner agreements* so that implementation and operations expectations are clearly defined. Conventions that are established in a *trading partner agreement* will take precedence over any conventions that are contained in this document.

Caution should be exercised when changing conventions for a single trading partner. Differences in conventions between trading partners will introduce additional complexity into the process of exchanging the transaction with multiple, different trading partners.

The flexibility of the 278 transaction allows for information to be recorded in a variety of places. General information about procedures and services should always be recorded in the UM and DTP segments of Loop 2000F. Specific information about procedures and services can be recorded in the HI/HSD segments and/or in segments CR1, CR2, CR5, CR6. Each health plan's *trading partner agreement* should specify any preferences about which segments should be used.

This document assumes that the following data elements will be specifically described in a trading partner agreement.

- Identifying information about the sender and the receiver of this transaction. This information is contained in a number of fields including fields ISA05-ISA08 of the ISA segment and fields GS02-GS03 of the GS segment.
- Identification information about the health care provider (individual or organization) that is requesting service review information. This information is contained in a number of fields including NM103-NM109 of the Requested Name segment (Loop 2010B) of the 278 request transaction.

The *trading partner agreements* will also describe how telecommunication connections will be made for the purpose of conducting these transactions.

Purpose of Assumptions & Conventions

The underlying premise of the Companion Guide is that the ASC X12N Health Care Services Review - Request for Review and Response (278) Implementation Guide defines the superset of business functionality. That ASC X12N guide also provides general information about EDI transmission, such as delimiters, enveloping, and related topics, and the Companion Document will not duplicate these efforts.

In order to establish a simplified implementation environment, the Health Services Review Companion Document describes a set of understandings, assumptions and conventions that will be followed by provider and health plan trading partners as they implement the transaction and interpret the information that is contained within it. These conventions provide additional clarity about data structures and the data elements ('what they mean') and describe how these data elements relate to information contained in the information systems belonging to each trading partner ('how they will be used').

Note: These conventions apply to transaction exchange between providers and commercial health plans and *may* not apply to:

- **Exchanges between providers and public programs such as Medicare and Medicaid. For more information about these programs, providers should check with www.cms.gov.**
- **Exchanges between providers and clearinghouses. For more information providers should check with their clearinghouse.**
- **Exchanges between health plans and health plans, if and where it happens.**

This Companion Document does not add, delete or change the name of any data element that is specified in the Implementation Guide. However, in order to meet the business objectives outlined above, it does recommend a number of conventions that are intended to clarify and standardize the usage of specific data elements, including:

- The Implementation Guide identifies some data segments and data elements that are not used by a health plan in processing approvals/authorizations of service requests. These data segments and data elements are highlighted in the System Interface Map section of this

Companion Document so that providers and intermediaries will not waste time determining health plan specific requirements. These situations will be designated on the System Interface Map with one of the following notes:

- *Not Used in Review/Approval Processes* -- This note will be used when the data element is situational. The use of this data element, and the information entered into it, must comply with the Implementation Guide. The health plan will not use this information in their review/approval of a requested service.'
- *Field must be populated with a valid value. It will not be used to process the review/ approval of a requested service* -- This note will be used when the data element is required. The use of this data element, and the information entered into it, must comply with the Implementation Guide. The health plan will not use this information in their review/approval of a requested service.'
- The Implementation Guide identifies a number of data elements that have a broad range of possible values. In some cases, many of these values are not relevant to a health plan. In other cases, values that are listed do not clearly relate to relevant business situations. In still other cases, the description of a value is confusing. In these situations,
 - Values that are not meaningful to health plans will be designated on the System Interface Map with a strikethrough (e.g. ~~value~~).
 - A clarifying comment may be enclosed in brackets and added after the description (e.g. 01 – Value Description [Clarifying Comment]). The comment is not intended to change the meaning of the value, but to add information about the conditions under which it will be used.
- If a health plan, provider or intermediary intends to use the message text for any reason, that intent should be discussed with all trading partners and documented in the Trading Partner agreements.

Intent and Scope of the Health Services Review Transaction

The Health Care Services Review - Request for Review and Response (278) transaction set will be used to convey information about request for health services between health plans and provider organizations. The intent of this transaction is to:

- Allow providers to notify health plans about services and procedures being requested for a patient (Request transaction).
- Allow health plans to communicate authorization or denial information pertaining to requested services and procedure (Response transaction).

The 278 transaction will convey information about a number of different types of communications between providers and health plans. These communications are called a variety of names including Referral, Prior-Authorization, Pre-Authorization, Pre-Certification, etc. The common element is always a notification about services to be rendered to a patient. Key differences are a) what type of provider initiates the notification, b) who receives the notification – another provider or a health plan, and c) whether the requested services can be rendered prior to some form of acknowledgment and/or confirmation from a health plan

Unfortunately, the names of these communications are not standardized. They mean different things to different people. To minimize confusion, the following definitions will be used in order to describe the scope of this transaction.

- A **Referral** is the communication between two healthcare providers about care to be delivered to a patient. In some, but not all cases, a health plan may be involved in this communication. Typically a PCP is the ‘requesting provider’ and a specialist or facility is the ‘service provider’ The services can be outpatient services, inpatient services, home services, or any other services.
- A **Health Plan Notification** is the communication between a healthcare provider (typically a facility, but it could also be a person) and a health plan about services that should be rendered to a patient by that provider. These services can be outpatient services, inpatient services, home services, or any other services. A Health Plan Notification will happen prior to a claim being submitted for the service.
- In order to meet their financial responsibility, health plans may need to be aware of some, but not all, referrals. They are always involved in the Health Plan Notification. Health plan policy identifies when and how a health plan wants to be involved in either or both of these situations. For the purpose of this discussion, the communication received by a health plan, whether it is part of the Referral communication or the Health Plan Notification communication, will be generically called a **Request**. In those cases when health plan policy calls for health plan involvement, the 278 transaction will be used to communicate request related information between providers and health plans.
- Health plan involvement and processing of a Request varies depending upon the care services to be rendered and the policy of the particular health plan as it relates those care services. In some situations, processing will vary by product line within a health plan. Typically however, processing of Requests fall into one of the following cases:
 - No Request Required: In this case, health plans do not want to be notified about the services to be delivered. If they receive a request, they may or may not process it. Some health plans will try to communicate to the provider that a request is not required.
 - Request Required - Will be Acknowledged: In this case, health plans want to be notified about the service to be delivered. However, care can be rendered by the provider(s) without awaiting any communication from the health plan. One of the providers will

notify the health plan of the request. The health plan may acknowledge receipt of the request. The health plan will not provide confirmation or authorization information.

- Request Required – Will be Confirmed: In this case, health plans want to be notified about the services to be delivered and will reply with confirmation information. Some health plans will verify eligibility before replying with confirmation, others will not. Care can be rendered by the providers without awaiting confirmation from the health plan. However, if a confirmation number is provided, it needs to be included when a claim is prepared and sent. One of the providers will notify the health plan of the request. The health plan will acknowledge receipt of the request and will reply with confirmation information or a not eligible message (in those situations when a health plan verifies eligibility).
- Request Required – Will be Authorization: In this case, health plans want to be notified about the services to be delivered and will reply with either an approval or a denial. The approval or denial indicates the health plan's responsibility to cover some or all of the cost of the services. Health plans will verify eligibility, benefits and medical necessity before providing authorization information. Care should not be rendered by the providers without receiving authorization from the health plan. The authorization number needs to be included when a claim is prepared and sent. One of the providers will notify the health plan of the referral. The health plan will acknowledge receipt of the request and will reply with authorization information.

The 278 transaction will be used in all of these cases.

Not in Scope of the Health Services Review Transaction

The following transactions are not yet mandated by HIPAA and are not addressed within the scope of this Companion Document.

- 004010X111 – Health Care Services Review Notification: Intended to be used in the following situations:
 - patient arrival notice
 - patient discharge notice
 - certification change notice
 - notification of certification to primary provider(s), other provider(s), and UMOs
- 004010X059 – Health Care Services Review Inquiry/Response: Intended to be used to request information about a previously submitted 278 request

Business Needs not yet accommodated within the Health Services Review Transaction

A number of business needs have been identified that are not yet accommodated within the 278 004010X094A1 Health Services Review transaction. In some cases, workarounds are being proposed by various entities. Any workaround must be uniformly adopted by all interested trading partners.

- The following information about patient condition is not available as standard code values:
 - Pain – Mild
 - Pain – Moderate
 - Pain – Severe
 - Restrictions to Activities of Daily Living – Mild
 - Restrictions to Activities of Daily Living – Moderate
 - Restrictions to Activities of Daily Living – Severe

- A two way notification and acknowledgment is not supported

DSMO CRID 496 proposes that the 278 Request and Response implementation guide (004010X094A1) be amended to support Health Care Services Review Notifications and their Acknowledgments. X12N-TG2-WG10 discussed this proposal and recommended a 4010 solution for Notifications. (Available through x12ntg2wg10@disa.org). Modification and use of the existing 278 HIPAA implementation for notifications and acknowledgments must be established through trading partner agreement. This notification and acknowledgment transaction should not be subject to certification under HIPAA until a new rule adopts it as a standard for use with the current or some future HIPAA implementation of the 278.

A more comprehensive solution will be provided in a later version of the 278 Health Care Services Review Request and Response implementation guide. It is anticipated that a new rule will adopt this business event as an additional standard use of the 278

- Information included on a Certificate of Medical Necessity (CMN) is not yet incorporated into a HIPAA mandated transaction.

Until the 275 – Attachment transaction is established as a standard under HIPAA , Medicare has proposed the following work-around for the Medicare DME carriers to use when processing a CMN using the 278.

Use the MSG segment in the 2000F loop to identify a CMN or other certification or authorization document that is being sent through another mode of communication (e.g., fax). The 80 positions in the MSG segment will be formatted to include information such as Sender, Receiver, Date Sent, Transmission Method, etc. You can use any data that will

clearly associate the 278 with the actual CMN.

- There are no viable elements for reporting procedure code modifiers.

X12N-TG2-WG10 recommends the following work-around:

Use the MSG segment of the Service Level (2000F) Loop. The proposed format would be variable length, accommodating for reporting modifiers for up to 12 potential Procedure Codes in the HI segment. However, a fixed length for each procedure will be used to accommodate up to four modifiers. This allows the data to be more easily parsed by translators when reading the MSG segment. The procedure for which the modifier is being reported will be identified in the MSG segment by the corresponding HI element for which that procedure is located. The following 8 bytes will be allocated for up to four modifiers for that procedure. If that procedure has less than four modifiers the remaining bytes are spaced filled. In the event that 12 procedures are reported in the HI and all 12 procedures have at least one modifier, a total of 144 bytes would be used of the MSG segment for this workaround.

If there is also a text message that needs to be sent, begin the text message with the word text. This will allow the text to be parsed more easily.

Examples:

1. HI segment contains 12 procedures and all 12 procedures have at least one modifier. There is also a text message. NOTE: XX represent blank fill or spaces.

MSG*HI01m1m2XXXXHI02m1XXXXXXHI03m1m2m3m4HI04m1XXXXXXHI05m1m2m3XXHI06m1m2m3m4HI07m1XXXXXXHI08m1m2XXXXHI09m1m2m3m4HI10m1XXXXXXHI11m1m2m3XXHI12m1XXXXXXtext this is example one.~

The 278 Response includes only the modifiers approved. In this example, 12 procedures are approved, but modifiers are only approved for procedure in HI01 and HI12 and there is no text message. The response would like as follows:

MSG*HI01m1m2XXXXHI12m1XXXXXX~

2. HI segment contains 5 procedures. Procedures submitted in HI02 and HI05 have modifiers for those procedures. There is also a text message.

MSG*HI02m1m2m3m4HI05m1XXXXXXtext this is example two~

The long-term solution is to use the SV segments in the 278, which already have dedicated fields for modifiers. This is currently under discussion by X12N TG2 WG10 as part of the development of the 4050 implementation guide.

Transaction Structure & Processing -- Batch Mode & Real Time Mode

The X12 structure allows for either one transaction type or for multiple transaction types to be transmitted in an ISA-IEA envelope. By convention, it is preferred that each transaction type be transmitted within its own ISA-IEA set. For example, if an electronic transmission between two trading partners contains referrals and claims, there will be two ISA-IEA envelopes; one for the referrals(278) and one for the claims (837).

This Companion document reflects conventions for **batch** and **real time** implementation of the ANSI X12 278 Health Care Services Review - Request for Review and Response transaction. **It is anticipated that the 278 transaction will be predominantly processed in batch mode.**

Structure of Transaction: GS-GE & ST-SE

The Transaction Set Control Numbers in ST02 and SE02 must be identical. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.

Scope of Transaction: ST to SE

A 278 transaction, request or response, will contain information for one patient event. All information between an ST and the corresponding SE will relate to requests for procedures/services that are made by a single requesting provider for one patient. The transaction may include services requests for one or more procedures/services from multiple service providers.

Per HIPAA regulations, if the information associated with any of the service providers and/or procedures/services is not correctly formatted from a syntactical perspective, the entire ST-SE will be rejected. The health plan will notify the submitting organization of the file rejection via a 997 transaction, or other method agreed upon in the trading partner agreement.

Batch Mode Processing

- The requesting provider, or their electronic intermediary, will send the 278 request transaction to the Utilization Management Organization (Health Plan) through some means of telecommunications and will not remain connected while the Utilization Management

Organization processes the transaction. The Utilization Management Organization (Health Plan) will send the 278 response transaction to the requesting provider, or their electronic intermediary, through some means of telecommunications.

- Health plans intend to respond, with some type of acknowledgment, to every batch of 278 requests that is received. This acknowledgment will be sent whether or not the provider, or their intermediary, requests it. The acknowledgment will indicate that the 278 request was received. The acknowledgment is not intended to convey confirmation or authorization.

In most cases, the acknowledgment will be a 997 transaction. In cases where the transaction is unreadable, the acknowledgment will either be a TA1 transaction or the health plan will contact the provider via phone or fax. The method of notification should be discussed as part of the *trading partner agreement*.

- If some or all of the ISA segment is unreadable or does not comply with the Implementation Guide AND if there is sufficient routing information that can be extracted from the ISA, the health plan will respond with an appropriate TA1 transaction or will contact the provider via phone/fax. Otherwise, the health plan will be unable to respond. In either case, the batch will not be processed.
- In all other cases, the health plan will respond with an appropriate 997 transaction to acknowledge receipt of the Batch. The 997 transaction will indicate whether or not the batch can be processed. If the GS segment of the batch does not comply with the Implementation Guide, the health plan may not be able to process the transaction.
- If the health plan is able to process the batch, a batch of 278 responses will be sent when processing is complete.

Real Time Mode Processing

- A real time transaction contains service information for one patient event. There will be a single transaction in a single envelope. As such, there will be one and only one of each of the following segments: ISA, GS, ST, SE, GE, IEA.

The requesting provider, or their electronic intermediary, will send the 278 request transaction to the Utilization Management Organization (Health Plan) through some means of telecommunications and will remain connected while the Utilization Management Organization processes the transaction and returns a 278 response.

Health Plans will respond to Real Time transactions within a minute. The speed of processing a real time transaction will depend upon how long it takes to match a 278 request to a previously submitted request.

- Health plans intend to respond, with some type of acknowledgment, to every real time 278 request that is received. This acknowledgment will be sent whether or not the provider, or

their intermediary, requests it. The acknowledgment will indicate that the 278 request was received. The acknowledgment is not intended to convey confirmation or authorization.

In most cases, the acknowledgment will be a 997 transaction. In cases where the transaction is unreadable, the acknowledgment will either be a TA1 transaction or the health plan will contact the provider via phone or fax. The method of notification should be discussed as part of the *trading partner agreement*.

- If some or all of the ISA segment is unreadable or does not comply with the Implementation Guide AND if there is sufficient routing information that can be extracted from the ISA, the health plan will respond with an appropriate TA1 transaction or will contact the provider via phone/fax. Otherwise, the health plan will be unable to respond. In either case, the batch will not be processed.
- If the GS is unreadable or does not comply with the Implementation Guide so that the health plan is not able to process the request, the health plan will respond with a 997.
- In all other cases, the health plan will process the 278 request and respond with a 278 response.

Transaction Processing – Version Control in Production Systems (not testing)

Per HIPAA regulations, providers must submit and health plans must be able to process the medical data code sets that are valid at the time that the service was rendered. (The validity of the medical data code set is determined by the service date not the transaction submit date.) This means that health plans must be able to process versions of the code sets that are earlier than the current version.

Per HIPAA regulations, providers must submit, and health plans must be able to process, only the version of the transaction (e.g. 4010, 4050, etc) that is valid at the time that the transaction is received by the health plan. HIPAA regulations do not allow health plans to process earlier or future versions of a transaction in their production systems. Only the current version of the transaction can be supported.

Transaction Processing – Health Plan Production System

A health plan's production system will process the data contained in a 278 request in one of three ways:

- *Reject It:* Rejected information is not compliant with the HIPAA standard. One example is transactions that are missing required fields. The transaction will be rejected.

- *Not Review It:* Not Reviewed information is compliant with the HIPAA standard but a) cannot be processed by the health plan's system (e.g. quantity or amount data fields that are outside the range of good business practices), or b) is not relevant to the processing logic (see References in System Interface Map). Though the data element will be reviewed, the transaction will not be processed within the health plan's production system.
- *Process It:* Processed information is compliant with the HIPAA standard and is consistent with health plan practices. The data element and the transaction will be processed within the health plan's production system.

Privacy and Security Protection

The Implementation Guide and the Companion Document DO NOT specifically address privacy and security protection regarding the use of system or application technology to send and receive this transaction set. For example, registration and management of users, assignment and exchange of passwords, ID, digital certificates, etc., authentication, authorization and other access restrictions are not addressed in either of these documents. Information about those protections will typically be contained in a Trading Partner Agreement or a Business Associate Agreement. This document assumes that the exchange of this transaction will take place in a processing and communication environment that is secure at both ends – sender and receiver.

General Usage

1. The 278 request transaction may be sent by an electronic intermediary, acting on the behalf of the requesting provider, or may be sent by the requesting provider. Information about the sender of the transaction will be placed in the ISA segment and the GS segment.

Loop 2000B, Requester Level, will contain information about the Requesting Provider. The Requesting Provider will be the person or entity that is requesting the clinical services.

- If the sender of the transaction is an electronic intermediary acting on behalf of the requesting provider -- the ISA segment and the GS segment will identify the intermediary. The requesting provider will be identified in the 2000B Loop (Requester Level). Each service provider will be identified in one occurrence of the 2000E Loop (Service Provider Level).
- If the sender of the transaction is the requesting provider -- the ISA segment, the GS segment and the 2000B Loop (Requester Level) will identify the requesting provider. Each service provider will be identified in one occurrence of the 2000E Loop (Service Provider Level).

2. The Health Plans processing system will look to match a 278 request with an eligible patient using the following data fields:

- Member Identification Number (NM109 of Loop 2010C)
- Date of Birth (DMG02 of Loop 2010D)
- Lastname (NM103 of Loop 2010D)
- Firstname (NM104 of Loop 2010D)

If a match cannot be found, a not found message will be sent.

3. When information contained in the 278 Request conflicts with information stored in the health plan's system, the 278 Response will contain the information in the health plan's system. (This is similar to the convention used in the 270-271 & 276-277 transactions.)

However, the REF segment of Loop 2010C of the 278 Response, Subscriber Supplemental Identification, will always contain the information that was provided in the corresponding segment of the 278 Request regardless of what information is stored in the health plan's system.

4. There are various reasons why a 278 Request could not be processed by the health plan within their production system. In those cases when a 278 Request cannot be processed, a 278 Response will be returned with appropriate AAA segment(s) that indicates the reason.

Before returning a 278 Response, health plans will attempt to find all possible error conditions and to identify those conditions with the appropriate AAA segments. However, there are likely to be circumstance when the health plan stops processing upon reaching the first error condition that is found, and will return the 278 Response with the appropriate AAA segment. ('Out of Network Provider', AAA03, is one possible example.)

The AAA segment of Loop 2000A in the 278 Response transaction will not be used by health plans. It is assumed that this segment will only be used by clearinghouses and intermediaries responding to 278 Request transactions received from providers.

5. For a number of data elements, the HIPAA Implementation Guide specifies a field length that represents unrealistic situations or that is outside of good business practices. One example is a dollar amount of \$100,000,000,000,000. In these situations, health plans will accept the submitted data element but may not process it within their production system. The transaction will be returned to the sender with an appropriate error message in an AAA segment.

6. In the 278 response, some health plans may create a separate 2000F Loop for every procedure (HI segment) and/or service delivery pattern (HSD segment) that is returned. For example, if 3 procedures were requested on the same 278 request and the health plan approved two of them and denied one of them, then there would be three 2000F loops – two with an HCR01 = A1 and the other with an HCR01 = A3.

Other health plans may group procedures and service delivery patterns by trace number (TRN02) AND action code (HCR01), e.g. Denied, Approved/Authorized. For example, if 3 procedures were requested on the same 278 request and the health plan approved two of them and denied one of them, then there would be two 2000F loops – one with an HCR01 = A1 and the other with an HCR01 = A3.

In some cases, health plans will approve a request that was modified from how it was originally submitted. For example, 2 visits may be approved when 3 visits were requested. In these cases, a 2000F loop of the 278 response will contain a TRN segment with TRN02 = the trace number of the 278 request, an HCR segment with HCR03 = A6, and the appropriate description of the service or procedure (HI segment and/or HSD segment).

Handling Likely Situations

1. **SITUATION:** There is a difference between information contained in the 278 request and information the health plan has on file.

ACTION: The 278 response will always reflect the information that the health plan has on file.

EXAMPLE: Subscriber Name is identified in the 278 request as a Fred Flintstone, but the health plan system has the Subscriber Name as Frederick Flintstone. The health plan will return a 278 response with the name Frederick Flintstone.

2. **SITUATION:** The health plan cannot reply to a 278 request with a complete 278 response because one or more of their systems are not operational.

ACTION: The health plan will reply with a 278 response that contains an AAA segment in the 2000A Loop. The AAA03 field will contain an '42' (Unable to Respond at Current Time).

3. **SITUATION:** The health plan cannot uniquely match a requesting provider identified in the 278 request to a provider in their database.

ACTION: The health plan will reply with a 278 response that contains an AAA segment in the 2010B Loop. The AAA03 field will contain a '51' (Provider Not on File).

4. **SITUATION:** The 278 request did not contain enough information about the subscriber to allow the health plan to find a unique match in their database.

ACTION: The health plan will reply with a 278 response that contains an AAA segment in the 2010C Loop. The AAA03 field will contain a '15' (Required Application Data Missing).

Technical

1. Any character that is used in a data field cannot be used as a delimiter, separator or terminator. Ideally, the following characters will not be contained in data fields; asterisks, single quotes, double quotes, number sign, colon, and tilde.
2. By convention, preferred field delimiters will be: '*' – for data element separator, ':' for sub element separator, '~' for segment terminator.
3. If a person's name cannot be parsed into individual components (e.g. lastname, firstname, MI) in an NM segment, then NM102 should contain a '2' to indicate a non-person entity. This will indicate that work is required to process the field.
4. The NM107 field in the NM segment (Name Suffix) may contain suffix (Sr. Jr. or III) or degree (MD, Phd) or credential.