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Version 1.1

HITSP Patient Health Plan Authorization Request and Response

HITSP/T68

Submitted to:

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DOCUMENT CHANGE HISTORY

Version Number	Description of Change	Name of Author	Date Published
	Template Updated to V2.4	Project Team	July 31, 2008
0.0.1	Review Copy	Administrative and Financial Domain Technical Committee	September 26, 2008
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1.0.1	Review Copy	Administrative and Financial Domain Technical Committee	June 30, 2009
1.1	Released for Implementation	Administrative and Financial Domain Technical Committee	July 8, 2009

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FIGURES AND TABLES

1.0 INTRODUCTION

1.1 OVERVIEW

This HITSP Patient Health Plan Authorization Request and Response Transaction is intended to provide a mechanism for a healthcare provider (other than a retail pharmacy) to request approval from a health plan to authorize certain healthcare services, when required by the patient's health plan contract. The health plan responds to the healthcare provider(s) authorization request for approval of service(s). The information exchanged includes, but is not limited to, approval status for coverage, allowed service provider(s), and certification dates for services that are included in the patient's health plan benefits. The response from the health plan indicates that the health plan has determined that the particular service(s) will or will not be covered, and what is the level of coverage if that information is available from the health plan.

The term "Health Plan" as used in this document encompasses a review entity, utilization management organization, payer, third party administrator, processor, health plan, or any entity performing the authorization approval process on behalf of the health plan. While each of these entities may perform other functions in the healthcare arena, the function is grouped together in this guide, under one term "Health Plan".

To support Patient Health Plan Authorization Request and Response Transaction, the HITSP Administrative and Financial Domain Technical Committee (DTC) is using the Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guide Version 004010X94 plus Addenda 004010X94A1. This X12N Implementation Guide is also being constrained by the HITSP Technical Committee to facilitate the exchange of the HIPAA adopted X12N 278 Health Care Service Review Information Transactions between a healthcare provider (Information Requester) and a utilization management organization (Information Source). The X12N 278 Health Care Service Review Information Transactions is a bi-directional transaction set consisting of two transactions; the first transaction is used to request a healthcare service review and the second transaction is the associated response to that request.

This Transaction may not define all functions, constructs and standards necessary to implement a conforming system in a real world environment. In particular, an implementer must provide the technical infrastructure and security framework necessary to support operations in accordance with law, regulation, best practices and business agreements.

1.2 COPYRIGHT PERMISSIONS

1.3 REFERENCE DOCUMENTS

This section provides a list of key reference documents and background material.

A list of key reference documents and background material is provided in the table below. These documents can be retrieved from www.hitsp.org.

Table 1-1 Reference Documents

Reference Document	Document Description
HITSP Acronyms List	Lists and defines the acronyms used in this document
HITSP Glossary	Provides definitions for relevant terms used by HITSP documents
TN900 - Security and Privacy	TN900 is a reference document that provides the overall context for use of the HITSP Security and Privacy constructs

1.4 CONFORMANCE

This section describes the conformance criteria, which are objective statements of requirements that can be used to determine if a specific behavior, function, interface, or code set has been implemented correctly.

1.4.1 CONFORMANCE CRITERIA

In order to claim conformance to this construct specification, an implementation must satisfy all the requirements and mandatory statements listed in this specification, the associated HITSP Interoperability Specification, its associated construct specifications, as well as conformance criteria from the selected base and composite standards. A conformant system must also implement all of the required interfaces within the scope, subset or implementation option that is selected from the associated Interoperability Specification.

Claims of conformance may only be made for the overall HITSP Interoperability Specification or Capability with which this construct is associated.

1.4.2 CONFORMANCE SCOPING, SUBSETTING AND OPTIONS

A HITSP Interoperability Specification must be implemented in its entirety for an implementation to claim conformance to the specification. HITSP may define the permissibility for interface scoping, subsetting or implementation options by which the specification may be implemented in a limited manner. Such scoping, subsetting and options may extend to associated constructs, such as this construct. This construct must implement all requirements within the selected scope, subset or options as defined in the associated Interoperability Specification to claim conformance.

2.0 TRANSACTION DEFINITION

2.1 CONTEXT OVERVIEW

This HITSP Patient Health Plan Authorization Request and Response Transaction document is used to provide information about a patient's health insurance related to healthcare services when a payer authorization is required for purposes of benefit coverage determination.

Implementations of this Transaction shall support the specification as defined by the Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides Version 004010X94 plus Addenda 004010X94A1.Additionally implementations shall support the additional HITSP constraints as defined in Section 2.1.1.

This Transaction does not include the Authorization Request and Response from a retail pharmacy to a health plan.

This Transaction is not used for a healthcare provider to notify the health plan of a patient encounter or admission.

2.1.1 TRANSACTION CONSTRAINTS

The table below identifies the constraints at a high level. The actual requirements are in Table 2-8 X12N 278 Request for Review Data Mapping and Response Data Mapping.

Table 2-1 Transaction Constraints

Constraint
For 278 Request for Review, the BHT02-353 Transaction Set Purpose Code shall be "13" for Request
For 278 Response to Request for Review, the BHT02-353 Transaction Set Purpose Code shall be "11" for Response
For 278, the Information Receiver shall be the Provider and shall be identified using code "XX" for the Healthcare Financing Administration National Provider Identifier (NPI) (which then requires the Identification Code)
For 278, the Information Source shall be the health plan and shall be identified using either code "PI" for Payer Identifier or code "XV" for Healthcare Financing Administration Payer Identifier Number (which then requires the Identification Code)
The GS01-479 Functional Identifier Code shall be "HI" Health Care Services Review Information for the 278 and the value of the GS08-480 Version/Release/Industry Identifier code shall be 004010X094A1
The individual patient who is the subject of the 278 Request for Review shall be identified in the Subscriber Loops using the individual's First Name, Last Name, Member Identifier and Date-of-Birth
The individual patient who is the subject of the 278 Response to Request for Review shall be identified in the Subscriber Loops using the individual's First Name, Last Name, Member Identifier and Date-of-Birth
The Procedure Code and the associated Code List Qualifier shall be required if known, in the 278 Request for Review at the Service Level
The Procedure Code and the associated Code List Qualifier shall be required if known, in the 278 Response to Request for Review at the Service Level

2.1.2 INTERFACES

Table 2-2 Interfaces

Interface	Description	Used in Component/ Standard	Transaction/Content	T/C Optionality[1]
Information Receiver for Health Plan Authorization	The system that initiates a request to the Information Source for Health Plan Authorization about an individuals health insurance requirements to obtain an authorization approval for purposes of benefit coverage determination in order to refer a patient for healthcare services	Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides Version 004010X94 plus Addenda 004010X94A1	Health Plan Authorization Information Request	R
			Health Plan Authorization Information Response	R
Information Source for Health Plan Authorization	The system which holds and maintains the information regarding the individual's health insurance requirements related to an authorization for benefit coverage	Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides Version 004010X94 plus Addenda 004010X94A1	Health Plan Authorization Information Request	R
			Health Plan Authorization Information Response	R

Implementation Constraints

Table 2-3 Interface and Transaction/Content Constraints

Constraint Code	Constraint Description
No applicable implementation constraints	NA

2.1.3 INTERFACE INTERACTIONS

Figure 2-1 Authorization Flow Diagram

A provider, other than a retail pharmacy, needs an authorization from the patient's health plan in order for a healthcare service to be covered by the heath plan. This Transaction is used to provide the approval status by a health plan covering the individual. The healthcare service review request is initiated via the X12N 278 Request for Review and the information is returned via the X12N 278 Response to Request for review.

[1] Optionality = "R" for Required, "R2" for Required if Known, "O" for Optional, or "C" for Conditional

2.1.4 PRE-CONDITIONS

Table 2-4 Pre-conditions

Pre-condition
Health plan is known by the provider
Individual is known to the health plan
It is expected that the security framework under which this Transaction operates is in accordance with the Interoperability Specification that references this construct. Therefore all applicable HITSP Security and Privacy constructs are implemented as required

2.1.4.1 PROCESS TRIGGERS

Table 2-5 Process Triggers

Process Trigger
Any Information Receiver for Health Plan Authorization (systems used by physicians, clinics, hospitals, etc) submits requests to the patient's health plan for authorization
Healthcare Provider knows that an authorization must occur

2.1.5 POST-CONDITIONS

Table 2-6 Post-conditions

Post-condition
The Information Receiver for Health Plan Authorization processes the response received from the Information Source for Health Plan Authorization

2.1.5.1 REQUIRED OUTPUT

Table 2-7 Required Output

Required Output	Format/Usage
The Information Receiver for Health Plan Authorization provides authorization status information to the user of the system	Via user interface

2.1.6 DATA FLOWS[2]

Below are the data mappings and HITSP constraints for the X12N 278 Health Care Service Review Information Transactions version 004010X94 and Addenda 004010X94A1.

The legend for transaction set data element mapping follows the format below:

<transactionsetid>_<loopid>_<segment & data element position in segment>_X12 data element #>

For example:

278_2010B_NM101_98

Not all segments are in a loop (segment group); thus <loopid> cannot always be specified. This legend uses an asterisk "*" to designate no <loopid> is applicable.

For example:

[2] HITSP Transaction constrains certain portions of this X12N 278 Implementation Guide. The Implementation Guide contains other capabilities that are outside the scope of this transaction.

278_*_BHT02_353

This use of an asterisk “*” is also used for Control Segments GS/GE, ST/SE where HITSP constraints may be applied.

For example:

*_*_GS01_479

Table 2-8 X12N 278 Request for Review Data Mapping and Response Data Mapping

Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements / Pre-conditions[3]	Additional Specification for Component
*_ *_GS01_479	Functional Identifier Code	HI - Health Care Service Review Information (278)	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Shall be a value of HI
*_ *_GS08_480	Version/Release/Industry Identifier Code	004010X094A1 - Standards approved for publication by ASC X12 Procedures Review Board through October 1991 as published	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Shall be a value of 004010X094A1
278_*_BHT02_353	Transaction Set Purpose Code	13 - Request	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Shall be a value of 13
278_2000F_HI01-1_1270	Code List Qualifier Code Procedures		Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R2	Send more specific procedure code if known. Possible code sets allowed are NUBC Revenue codes, Level 1 HCPCS, ICD-9 –CM procedures, ADA tooth number, NDC drug codes
278_2000F_HI01-2_1271	Procedure Code	NA	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R2	NA
278_2010A_NM102 1065	Entity Type Qualifier Information Source Name	2 - Non Person Entity	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Shall be a value of 2
278_2010A_NM108_66	Identification Code Qualifier Information Source Name	PI - Payer Identifier or XV - Healthcare Financing Administration National Payer Identifier Number	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Note: By requiring this data element, data element NM109 is required (Identification Code Description)

[3] Optionality = "R" for Required, "R2" for Required if Known, "O" for Optional, or "C" for Conditional

Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements / Pre-conditions[3]	Additional Specification for Component
278_2010B_NM108 66	Identification Code Qualifier Requester Name	XX - Healthcare Financing Administration National Provider Identifier	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Shall be a value of XX Note: By requiring this data element, data element NM109 is required (Identification Code Description)
278_2010CA_DMG01 1250	Date Time Period Format Qualifier	D8 - CCYYMMDD	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Shall be a value of D8
278_2010CA_DMG02 1251	Date Time Period Subscriber Birth Date	NA	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Shall be the Subscriber Birth Date
278_2010CA_NM103 1035	Name Last Subscriber Name	NA	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	NA
278_2010CA_NM104 1036	Name First	NA	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R2	NA
278_2010CA_NM108 66	Identification Code Qualifier Description	MI - Member Identification Number	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Shall be a value of MI Note: By requiring this data element, data element NM109 is required (Identification Code Description)
278_2010E_NM108 66	Identification Code Qualifier Service Provider Name	XX - Healthcare Financing Administration National Provider Identifier	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Shall be a value of XX Note: By requiring this data element, data element NM109 is required (Identification Code Description)

Table 2-9 X12N 278 Response to Request for Review Data Mapping

Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements / Pre-conditions[4]	Additional Specification for Component
*_ *_GS01_479	Functional Identifier Code	HI - Health Care Service Review Information (278)	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be a value of HI
*_ *_GS08_480	Version/ Release/ Industry Identifier Code	004010X094A1 - Standards approved for publication by ASC X12 Procedures Review Board through October 1991 as published	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be a value of 004010X094A1
278_*_BHT02_353	Transaction Set Purpose Code	11 - Response	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be a value of 11
278_2000F_HI01_C022	Procedures	NA	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R2	Send more specific procedure code if known. Possible code sets allowed are NUBC Revenue codes, Level 1 HCPCS, ICD-9 –CM procedures, ADA tooth number, NDC drug codes
278_2000F_HI01-1_1270	Code List Qualifier Code Procedures	NA	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R2	Send more specific procedure code if known. Possible code sets allowed are NUBC Revenue codes, Level 1 HCPCS, ICD-9 –CM procedures, ADA tooth number, NDC drug codes
278_2000F_HI01-2_1271	Procedure Code	NA	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R2	NA
278_2010A_NM102 1065	Entity Type Qualifier Information Source Name	2 - Non Person Entity	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be a value of 2

[4] Optionality = “R” for Required, “R2” for Required if Known, “O” for Optional, or “C” for Conditional

Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements / Pre-conditions[4]	Additional Specification for Component
278_2010A_NM108_66	Identification Code Qualifier Information Source Name	PI - Payer Identifier or XV - Healthcare Financing Administration National Payer Identifier Number	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be a value of PI or XV Note: By requiring this data element, data element NM109 is required (Identification Code Description)
278_2010B_NM108 66	Identification Code Qualifier Requester Name	XX - Healthcare Financing Administration National Provider Identifier	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be a value of XX Note: By requiring this data element, data element NM109 is required (Identification Code Description)
278_2010CA_NM103 1035	Name Last Subscriber Name	NA	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	NA
278_2010CA_NM104 1036	Name First	NA	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R2	NA
278_2010CA_NM108 66	Identification Code Qualifier Description	MI - Member Identification Number	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be a value of MI Note: By requiring this data element, data element NM109 is required (Identification Code Description)
278_2010CA_DMG01 1250	Date Time Period Format Qualifier	D8 - CCYYMMDD	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be a value of D8
278_2010CA_DMG02 1251	Date Time Period Subscriber Birth Date	NA	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be the Subscriber Birth Date
278_2010E_NM10 66	Identification Code Qualifier Service Provider Name	XX - Healthcare Financing Administration National Provider Identifier	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	Shall be a value of XX Note: By requiring this data element, data element NM109 is required (Identification Code Description)

2.2 LIST OF HITSP CONSTRUCTS

Table 2-10 List of HITSP Constructs

Construct Name	Description	Transaction/Content
No applicable HITSP constructs		

2.2.1 CONSTRUCT DEPENDENCIES

Table 2-11 Construct Dependencies

Construct	Depends On (Name of Component that it depends on)	Dependency Type (Pre-condition, post-condition, general)	Purpose (Reason for this dependency)
No applicable dependencies			

2.2.2 ADDITIONAL CONSTRAINTS ON REQUIRED CONSTRUCTS

Table 2-12 Additional Constraints on Required Constructs

Data Element	Construct	Constraint	Constraint Type (Pre-condition, post-condition, general)	Purpose (Reason for this constraint)
No applicable constraints				

2.3 STANDARDS

2.3.1 REGULATORY GUIDANCE

Table 2-13 Regulatory Guidance

Regulation	Description
Health Insurance Portability and Accountability Act (HIPAA) – Administrative Simplification	A listing of national standards plus rules adopted by federal regulation for electronically communicating specified administrative and financial healthcare transactions, and protecting the security and privacy of healthcare information, as applied to the three types of defined covered entities: health plans, healthcare clearinghouses, and healthcare providers who conduct any of the specified healthcare transactions. For more information see the Code of Federal Regulations, Title 45, Parts 160, et. Seq.

2.3.2 SELECTED STANDARDS

Table 2-14 Selected Standards

Standard	Description
Accredited Standards Committee (ASC) X12 278 Transaction Version Standards Release 004010	The objective of the Health Care Eligibility/Benefit Inquiry (270) is to provide for the exchange of eligibility inquiry to individuals within a health plan. This transaction can be used by health care providers to request coverage and payment information on the member/insured in a batch environment where real time processing is not required. This transaction is also used to provide additional patient eligibility information to support administrative reimbursement for health care products and services. This standard is required by HIPAA

Standard	Description
Accredited Standards Committee (ASC) X12 278 transactions standard version 4010, using the Insurance Subcommittee (X12N) Addenda 004010X94A1	Many of the version X12N 004010 Implementation Guides, including all of those adopted under HIPAA, have Addenda that contain updates – only – to the original Implementation Guides. These Addenda are identified as version 004010A1. Implementation Guide 004010X0941 describes transactions for Health Care Service Review – Request for Review and Response. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com. This standard is required by regulatory guidance
Accredited Standards Committee (ASC) X12 278 transactions standard version 4010, using the Insurance Subcommittee (X12N) Implementation Guides Version Reference Numbers 004010X94	Detailed Implementations Guide based on release 004010 of the X12 standards. These Implementation Guides provide details on the use of X12 standards to accomplish specific transaction functions. Some of the version 004010 Implementation Guides, but not all, have been adopted as Implementation Specifications under HIPAA. This standard is required by regulatory guidance. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com

2.3.3 INFORMATIVE REFERENCE STANDARDS

Table 2-15 Informative Reference Standards

Standard	Description
No applicable informative reference standards	

3.0 APPENDIX

The following sections include relevant materials referenced throughout this document.

No additional information at this time.

4.0 DOCUMENT UPDATES

The following sections provide the history of all changes made to this document.

4.1 DECEMBER 10, 2008

The changes in this construct address the following comments received during the Public Comment and Inspection Testing period (September 29 – October 24, 2008).

- 5046, 5099, 5098, 5100, 5101, 5612

This document has been modified to add "or acknowledgements" to the 278 response transaction line in Figure 2.1.3-1 Eligibility Verification Flow Diagram.

This document has been modified to change interface names in Figure 2.1.3-1 Eligibility Verification Flow Diagram from Health Plan Authorization Information Receiver to Information Receiver for Health Plan Authorization and from Health Plan Authorization Information Source to Information Source for Health Plan Authorization.

Editorial change to Table 2-14 Selected Standards in the description of Accredited Standards Committee (ASC) X12 278 transactions standard version 4010, using the Insurance Subcommittee (X12N) Addenda 004010X94A1:

- Second row: Version is 004010X094A1. It is missing the letter A

Change made in Table 2-15 Informative Reference Standards:

- Delete Reference Standard Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guide Version 004010X94 plus Addenda 004010X94A1the following standard. This standard already exists in Table 2-14 Selected Standards

Minor editorial changes were made to this construct.

4.2 DECEMBER 18, 2008

Upon approval by the HITSP Panel on December 18, 2008, this document is now Released for Implementation.

4.3 JUNE 30, 2009

Minor editorial changes were made to this document. Boilerplate text was removed for simplification. The term “actor” was replaced with “interface”.

4.4 JULY 8, 2009

Upon approval by the HITSP Panel on July 8, 2009, this document is now Released for Implementation.