

HITSP Patient Health Plan Authorization Request and Response Transaction

HITSP/T68



Healthcare Information Technology Standards Panel

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1.0 INTRODUCTION

1.1 OVERVIEW

This Healthcare Information Technology Standards Panel (HITSP) Patient Health Plan Authorization Request and Response Transaction is intended to provide a mechanism for a healthcare provider (other than a retail pharmacy¹) 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 requested service(s) has been approved, denied, pending, or modified. This response may include information related to the requested service(s), such as, effective date and expiration date of service authorization; what procedures or treatments were approved; quantity of treatments or services permitted, frequency and delivery patterns (weekly, monthly, etc); and other service specific information or limitations.

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 (AFDTC) is using the Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guide Version 004010X094 plus Addenda 004010X094A1. 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 HITSP 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

COPYRIGHT NOTICE

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1.3 REFERENCE DOCUMENTS

A list of key reference documents and background material is provided in the table below. HITSP-maintained reference documents can be retrieved from the www.hitsp.org Web Site.

¹ See HITSP/T79 Pharmacy to Health Plan Authorization Request and Response



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
TN903 – Data Architecture	TN903 is a reference document that provides the overall context for use of the HITSP Data Architecture constructs
TN904 – Harmonization Framework and Exchange Architecture	TN904 is a reference document that provides the overall context for use of the HITSP Harmonization Framework and Exchange Architecture

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. This includes information regarding, current condition and/or diagnosis, prognosis, procedures, treatment, and therapies related to a healthcare services request, when a health plan authorization is required for purposes of benefit coverage.

Implementations of this Transaction support the specification as defined by the Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides Version 004010X094 plus Addenda 004010X094A1. Additionally implementations support the additional HITSP constraints as defined in Section 2.2.2.

This Transaction does not include the Authorization Request and Response from a retail pharmacy to a health plan, which is covered in [HITSP/T79 Pharmacy to Health Plan Authorization Request and Response](#).

2.1.1 INTERFACES

Table 2-1 Interfaces

Interface	Description	Used in Component/ Standard	Transaction/Content	T/C Optionality
Information Receiver for Health Plan Authorization	The system that initiates a request to the Information Source for Health Plan Authorization for services to be provided to an individual when an authorization is required for benefit coverage purposes, or to refer a patient for healthcare services to another provider. An information receiver may be a provider or a consumer. The capability for a consumer to use this interface is an identified gap (See Section 2.1.3)	Accredited Standards Committee (ASC) X12 278 Transaction Set Version 004010, and the Insurance Subcommittee X12N Implementation Guide reference number 004010X094 plus its Addenda reference number 004010X094A1	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 benefits and health related requirements that will be used to determine if an authorization request can be authorized for benefit coverage, or must be denied, or deferred for further review	Accredited Standards Committee (ASC) X12 278 Transaction Set Version 004010, and the Insurance Subcommittee X12N Implementation Guide reference number 004010X094 plus its Addenda reference number 004010X094A1	Health Plan Authorization Information Request	R
			Health Plan Authorization Information Response	R

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



2.1.2 INTERFACE INTERACTIONS

Figure 2-1 Authorization Flow Diagram



A patient or 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 health 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. HITSP intends to address this Gap with X12 in 2010.

2.1.3 CONDITIONS AND ASSUMPTIONS

Table 2-2 Context

Assumptions, Pre-conditions, Post-conditions, and Triggers	Type of Context
Health plan is known by the provider	Pre-condition
It is expected that the security framework under which this Transaction operates is in accordance with the Interoperability Specification, Capability or Service Collaboration that references this construct. Therefore all applicable HITSP Security and Privacy constructs are implemented as required	Pre-condition
Provider initiates a request for authorization after receiving an eligibility response for a patient for healthcare benefits and coverage	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	Trigger

2.1.3.1 REQUIRED OUTPUT

Table 2-3 Required Output

Required Output	Format/Usage
The Information Receiver for Health Plan Authorization receives requested authorization information	

2.1.4 DATA FLOWS²

Below are the data mappings and HITSP constraints for the X12N 278 Health Care Service Review Information Transactions Version 004010X094 and Addenda 004010X094A1.

² HITSP Transaction constrains certain portions of Accredited Standards Committee (ASC) X12 278 Transaction Set Version 004010, and the Insurance Subcommittee X12N Implementation Guide reference number 004010X094 plus its Addenda reference number 004010X094A1. The Implementation Guide contains other capabilities that are outside the scope of this HITSP Transaction.



T68-[MSG-1-1]

Implementations of this Transaction **SHALL** support the specification as defined by the Accredited Standards Committee (ASC) X12 278 Transaction Set Version 004010, and the Insurance Subcommittee X12N Implementation Guide reference number 004010X094 plus its Addenda reference number 004010X094A1.

Implementations shall support the additional HITSP constraints defined in Section 2.2.2.

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

<transactionsetid>_<loopid>_<segmentname & 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:

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 2-4 X12N 278 Request for Review Data Mapping and Response Data Mapping

Constrain ID	ASC X12N Data Element	HITSP Data Element Identifier and Name	Data Source	Destination	Optionality	Additional Specification
T68-[MC-1-1]	*_*_GS01_479 - Functional Identifier Code	Message Control N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	T68-[MC-1-1] SHALL be a value of HI (Health Care Service Review Information (278))
T68-[MC-1-2]	*_*_GS08_480 - Version/Release/Industry Identifier Code	Message Control N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	T68-[MC-1-2] SHALL be a value of 004010X094A1 (Standards approved for publication by ASC X12 Procedures Review Board through October 1997 as published)
T68-[MC-1-3]	278_*_BHT02_353- Transaction Set Purpose Code	Message Control N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	T68-[MC-1-3] SHALL be a value of 13 (Request)
T68-[DQ-1-5]	278_2010A_NM102 1065 - Entity Type Qualifier Information Source Name	Data qualifier N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	T68-[DQ-1-5] SHALL be a value of 2 (Non Person Entity)
T68-[DQ-1-6]	278_2010A_NM108_66 - Identification Code Qualifier Information Source Name	Data qualifier N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	T68-[DQ-1-6] SHALL be a value of PI (Payer Identifier) or XV (Healthcare Financing Administration National Payer Identifier Number); NOTE: we may need to expand this contract to allow value 24 for Tax Identification Number, when the UMO is not the payer. Note: By requiring this data element, data element NM109 is required (Identification Code Description)
	278 2010A NM109 67 - Identification Code	5.03 - Health Plan Insurance Information Source ID	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	This may be a health plan or a different entity assigned by the health plan
T68-[DQ-1-7]	278_2010B_NM108 66 - Identification Code Qualifier Requester Name	Data qualifier N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	T68-[DQ-1-7] SHALL be a value of XX (Healthcare Financing Administration National Provider Identifier) or XV (Healthcare Financing Administration National Provider Identifier) Note: By requiring this data element, data element NM109 is required (Identification Code Description)



Constrain ID	ASC X12N Data Element	HITSP Data Element Identifier and Name	Data Source	Destination	Optionality	Additional Specification
	278 2010B NM109 67 - Identification Code	4.10 - National Provider ID	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	
	278_2010C_NM103 1035 - Name Last Subscriber Name	5.18 - Subscriber Name	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	
	278_2010C_NM104 1036 - Name First Subscriber Name	5.18 - Subscriber Name	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R2	
T68-[DQ-1-8]	278_2010CA_NM108 66 - Identification Code Qualifier Description	Data qualifier N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	T68-[DQ-1-8] SHALL be a value of MI (Member Identification Number) Note: By requiring this data element, data element NM109 is required (Identification Code Description)
	278 2010C NM109 67 - Identification Code	5.15 Subscriber ID	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Note: Number assigned by the health plan (payer).
T68-[DQ-1-7]	278_2010CA_DMG01 1250 - Date Time Period Format Qualifier	Data qualifier N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	T68-[DQ-1-7] SHALL be a value of D8
	278_2010CA_DMG02 1251 - Date Time Period Subscriber Birth Date	5.19 - Subscriber Date of Birth	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	
T68-[DQ-1-9]	278_2010E_NM108 66 - Identification Code Qualifier Service Provider Name	Data qualifier N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	T68-[DQ-1-9] SHALL be a value of XX (Healthcare Financing Administration National Provider Identifier) Note: By requiring this data element, data element NM109 is required (Identification Code Description)



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Constrain ID	ASC X12N Data Element	HITSP Data Element Identifier and Name	Data Source	Destination	Optionality	Additional Specification
	278 2010E NM109 67 - Identification Code	4.10 - National Provide ID	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Note: This is the provider who will be provided the requested service, which may be different from the requesting provider.
T68-[DQ-1-4]	278_2000F_HI01-1_1270 - Code List Qualifier Code Procedures	Data qualifier N/A	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R2	T68-[DQ-1-4] SHALL 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	17.01 - Procedure ID	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R2	

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

Table 2-5 X12N 278 Response to Request for Review Data Mapping

Constraint ID	ASC X12N Data Element	HITSP Data Element Identifier and Name	Data Source	Destination	Optionality	Additional Specification
T68-[MC-2-1]	*_*_GS01_479 - Functional Identifier Code	Message Control N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	T68-[MC-2-1] SHALL be a value of HI (Health Care Service Review Information (278))
T68-[MC-2-2]	*_*_GS08_480 - Version/Release/Industry Identifier Code	Message Control N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	T68-[MC-2-2] SHALL be a value of 004010X094A1 (Standards approved for publication by ASC X12 Procedures Review Board through October 1997 as published)
T68-[MC-2-3]	278_*_BHT02_353- Transaction Set Purpose Code	Message Control N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	T68-[MC-2-3] SHALL be a value of 11 (Response)
T68-[DQ-2-3]	278_2010A_NM102 1065 - Entity Type Qualifier Information Source Name	Data qualifier N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	T68-[DQ-2-3] SHALL be a value of 2 (Non Person Entity)



Constraint ID	ASC X12N Data Element	HITSP Data Element Identifier and Name	Data Source	Destination	Optionality	Additional Specification
T68-[DQ-2-8]	278_2010A_NM108_66 - Identification Code Qualifier Information Source Name	Data qualifier N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	T68-[DQ-2-8] SHALL be a value of PI (Payer Identifier) or XV (Healthcare Financing Administration National Provider Identifier) Note: By requiring this data element, data element NM109 is required (Identification Code Description)
	278 2010A NM109 67 - Identification Code	5.03 - Health Plan Insurance Information Source ID	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	This may be a health plan or a different entity assigned by the health plan.
T68-[DQ-2-9]	278_2010B_NM108 66 - Identification Code Qualifier Requester Name	Data qualifier N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	T68-[DQ-2-9] SHALL be a value of XX (Healthcare Financing Administration National Provider Identifier) Note: By requiring this data element, data element NM109 is required (Identification Code Description)
	278 2010B NM109 67 - Identification Code	4.10 - National Provider ID	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	
	278_2010C_NM103 1035 - Name Last Subscriber Name	5.18 - Subscriber Name	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	
	278_2010C_NM104 1036 - Name First Subscriber Name	5.18 - Subscriber Name	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R2	
T68-[DQ-2-10]	278_2010C_NM108 66 - Identification Code Qualifier Description	Data qualifier N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	T68-[DQ-2-10] SHALL be a value of MI (Member Identification Number) Note: By requiring this data element, data element NM109 is required (Identification Code Description)
	278 2010C NM109 67 - Identification Code	5.15 - Subscriber ID	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Note: Number assigned by the health plan (payer).



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Constraint ID	ASC X12N Data Element	HITSP Data Element Identifier and Name	Data Source	Destination	Optionality	Additional Specification
T68-[DQ-2-11]	278_2010C_DMG01 1250 - Date Time Period Format Qualifier	Data qualifier N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	T68-[DQ-2-11] SHALL be a value of D8
	278_2010C_DMG02 1251 - Date Time Period Subscriber Birth Date	5.19 - Subscriber Date of Birth	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	
T68-[DQ-2-12]	278_2010E_NM10 66 - Identification Code Qualifier Service Provider Name	Data qualifier N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R	T68-[DQ-2-12] SHALL be a value of XX (Healthcare Financing Administration National Provider Identifier) Note: By requiring this data element, data element NM109 is required (Identification Code Description)
	278 2010E NM109 67 - Identification Code	4.10 - National Provider ID	Information Receiver for Health Plan Authorization	Information Source for Health Plan Authorization	R	Note: This is the provider who will be provided the requested service, which may be different from the requesting provider.
T68-[DE-2-4]	278_2000F_HI01_C022 - Procedures	Composite data element, data elements populated below	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R2	T68-[DE-2-4] SHALL 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
T68-[DQ-2-5]	278_2000F_HI01-1_1270 - Code List Qualifier Code Procedures	Data qualifier N/A	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R2	T68-[DQ-2-5] SHALL 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	17.01 - Procedure ID	Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization	R2	

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



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2.2 LIST OF HITSP CONSTRUCTS

Table 2-6 List of HITSP Constructs

Construct Name	Description	Transaction/Content
No applicable HITSP constructs		

2.2.1 CONSTRUCT DEPENDENCIES

Table 2-7 Construct Dependencies

Construct	Depends On (Name of Component that it depends on)	Dependency Type (Pre-condition, Post-condition, General)	Purpose (Reason for this dependency)
HITSP/T68	HITSP/CAP141 – Communicate Referral Authorization	General	Addresses interoperability requirements that support electronic inquiry and response for a health plan authorization
HITSP/T68	HITSP/C154 – Data Dictionary	General	Identifies HITSP Data Elements that map to the HL7 Data Elements constrained by this Component

2.2.2 ADDITIONAL CONSTRAINTS ON REQUIRED CONSTRUCTS

Table 2-8 Additional Constraints on Required Constructs

Constraint ID	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 2-9 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 2-10 Selected Standards

Standard	Description
Accredited Standards Committee (ASC) X12 278 transactions standard version 4010, using the Insurance Subcommittee (X12N) Implementation Guides Version Reference Numbers 004010X094	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
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 004010X094A1 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

2.3.3 INFORMATIVE REFERENCE STANDARDS

Table 2-11 Informative Reference Standards

Standard	Reason for Use
No applicable informative reference standards	



3.0 APPENDIX

The following sections include relevant materials referenced throughout this document.

- A listing of all HITSP constraints defined within this document

3.1 HITSP CONSTRAINTS DEFINED IN THIS DOCUMENT

Table 3-1 Constraints

Constraint ID	Constraint Description
T68-[MSG-1-1]	Implementations of this Transaction SHALL support the specification as defined by the Accredited Standards Committee (ASC) X12 278 Transaction Set Version 004010, and the Insurance Subcommittee X12N Implementation Guide reference number 004010X094 plus its Addenda reference number 004010X094A1.
T68-[MC-1-1]	SHALL be a value of HI (Health Care Service Review Information (278))
T68-[MC-1-2]	SHALL be a value of 004010X094A1 (Standards approved for publication by ASC X12 Procedures Review Board through October 1997 as published)
T68-[MC-1-3]	SHALL be a value of 13 (Request)
T68-[DQ-1-4]	SHALL 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
T68-[DQ-1-5]	SHALL be a value of 2 (Non Person Entity)
T68-[DQ-1-6]	SHALL be a value of PI (Payer Identifier) or XV (Healthcare Financing Administration National Payer Identifier Number)
T68-[DQ-1-7]	SHALL be a value of XX (Healthcare Financing Administration National Provider Identifier) or XV (Healthcare Financing Administration National Provider Identifier)
T68-[DQ-1-8]	SHALL be a value of MI (Member Identification Number) Note: Number assigned by the health plan (payer)
T68-[DQ-1-9]	SHALL be a value of XX (Healthcare Financing Administration National Provider Identifier)
T68-[MC-2-1]	SHALL be a value of HI (Health Care Service Review Information (278))
T68-[MC2-2]	SHALL be a value of 004010X094A1 (Standards approved for publication by ASC X12 Procedures Review Board through October 1997 as published)
T68-[MC-2-3]	SHALL be a value of 11 (Response)
T68-[DQ-2-3]	SHALL be a value of 2 (Non Person Entity)
T68-[DQ-2-8]	SHALL be a value of PI (Payer Identifier) or XV (Healthcare Financing Administration National Provider Identifier) Note: By requiring this data element, data element NM109 is required (Identification Code Description)
T68-[DQ-2-9]	SHALL be a value of XX (Healthcare Financing Administration National Provider Identifier)
T68-[DQ-2-10]	SHALL be a value of MI (Member Identification Number). Note: Number assigned by the health plan (payer).
T68-[DQ-2-11]	SHALL be a value of D8
T68-[DQ-2-12]	SHALL be a value of XX (Healthcare Financing Administration National Provider Identifier)
T68-[DE-2-4]	SHALL 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
T68-[DQ-2-5]	SHALL 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



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 2-10 Selected Standards in the description of Accredited Standards Committee (ASC) X12 278 transactions standard Version 004010, using the Insurance Subcommittee (X12N) Addenda 004010X094A1:

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

Change made in Table 2-11 Informative Reference Standards :

- Delete Reference Standard Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guide Version 004010X094 plus Addenda 004010X94A1 the following standard. This standard already exists in Table 2-10 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.

4.5 NOVEMBER 9, 2009

The following changes/revisions were made to this construct:

Revised the document based on HITSP/TN903 Data Architecture

- Section 1.1 Changes to the overview text were made to add clarity. Addition of TN903 as a Reference to Table 1-11 Reference Documents.
- Section 2.1 Changes to the construct overview text were made to add clarity
- Section 2.1.1 Interface descriptions were updated



- Section 2.1.2 Descriptions of Interface Interactions were updated
- Section 2.1.4.1 Process Triggers were revised
- Section 2.1.4 Data Flow constraints were added and Table 2-55 X12N 278 Response to Request for Review Data Mapping was re-formatted per HITSP/TN903. Data mapping is now between ASC X12 Data Elements and HITSP Data Elements, Numbered constraints are now provided for Data Elements, Message Controls and Data Qualifiers
- Table 2-7 Construct Dependencies Constraint dependencies were added
- Appendix 3.1 HITSP Constraints Defined Section added

4.6 JANUARY 18, 2010

The document has been updated to reflect changes made to the HITSP Transaction template version 2.7

The following changes/revisions were made to address Public Comment

- Updated the transaction to the latest HITSP Transaction Template
- Updated version numbers to read 004010, 004010X094, and 004010X094A1
- Revised wording in Section 1.1 Overview to add clarity
- Revised wording in Section 2.1 Context Overview to add clarity
- Updated various constraint statement in Table 2-4 X12N 278 Request for Review Data Mapping and Response Data Mapping
- Updated various constraint statements in Table 2-5 X12N 278 Response to Request for Review Data Mapping
- Modified description of ASC X12 278 in Table 2-10 Selected Standards
- Added Table 3-1 Constraints
- The following public comments were addressed in this version of the transaction: 8047, 8211, 8247, 8248, 8249, 8250, 8251, 8252, 8253, 8254, 8255, 8256, 8257, and 9025

The full text of the comments along with the Technical Committee's disposition can be reviewed on the [HITSP Public Web Site](#).

4.7 JANUARY 25, 2010

Upon approval by the HITSP Panel on January 25, 2010, this document is now Released for Implementation.

