COMMUNITY HEALTH CHOICE

HIPAA Standard

Transaction Companion Guide

Health Care Services Review - Request for Review and Response

278

ASC X12N 278
Refers to the Implementation Guides
Based on X12 Version 005010
July 2011 Errata

Revision	Revision Date	Revision Notes
Initial Create	07/01/2011	Initial Create

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SECTION 1. INTRODUCTION

1.1 Purpose

The purpose of this Companion Guide is to assist Community Health Choice, Inc. ("CHC") contracted providers meet the requirements of the National Electronic Data Interchange Transaction Set Implementation Guide, issued as a technical guide to comply with the requirements Electronic Data Interchange ("EDI") requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). CHC has updated its data sets for EDI files utilizing the ASC X12 nomenclature.

This Companion Guide is designed to assist CHC contracted providers who request review of specialty care, treatment and admission. This Companion Guide covers the 278, file format. Using the data sets specified in this Companion Guide will assist CHC to process provider requests more efficiently and accurately.

1.2 Contact Information

If a CHC contracted provider submits a request for a review of specialty care, treatment and admission, an acknowledgement of receipt of the request will be issued. The authorization number will then be communicated in writing.
For technical assistance from CHC, providers may contact CHC Provider Relations, 713-566-6995 or 1-888-760-2600, email: providerrelations@communityhealthchoice.org. Technical assistance is available from 8:00 a.m. to 5:00 p.m.

1.3 Privacy and Security Statement

The HIPAA Privacy Regulation became effective April 14, 2003, and the compliance date for the Security Regulation is April 21, 2005. Covered entities must implement and coordinate the Privacy and Security Rules into their standard business practices and coordinate them with the electronic transmission of protected health information. CHC has trained all staff in the proper use and protection of protected health information and developed a set of administrative policies and procedures to support that effort.

One of the requirements of the HIPAA Privacy Rule is for covered entities to issue a Privacy Notice. The Health and Human Services Commission mailed to each Medicaid recipient a HIPAA Privacy Notice in March, 2003. The Notice can be viewed or downloaded from the State's claims administrator's web site. CHC issued its own Notice of Privacy Practices in April 2003, and the Notice can be viewed on CHC's Website at www.communityhealthchoice.org.

SECTION 2. 278 HEALTH CARE CLAIM PAYMENT AND ADVICE

This section is used to describe the **required** data values for claim status processing by CHC regarding status of Texas Medicaid claims. The 278 format is used for requesting review of specialty care, treatment and admission. This is the file that is sent to CHC for processing and CHC returns to the requester. As an assumption for these file formats, if the Subscriber is the same individual as the Patient then the Patient Loop is not to be populated per HIPAA compliance.

Form	Loop ID	Element ID	Data Value	Description
Control Segments				
Interchange Control Header				
278		ISA01	00	This specific data element needs to be populated for CHC purposes. “00” is utilized for no authorization information present. CHC will populate “00” in the 278 file for response.
278		ISA03	00	This specific data element needs to be populated for CHC purposes. “00” is utilized for no security information present. CHC will populate “00” in the 278 file for response.
278		ISA05	ZZ	Mutually Defined is used to submit this file format to CHC. CHC will populate ZZ in the 278 file for response.
278		ISA06		This is the Submitter ID that is specific to the submitter of the request. This ID is assigned to the submitter by CHC.
278		ISA06		This is the CHC ID used for recognition.
278		ISA07	ZZ	Mutually Defined is used to submit this file format to CHC. CHC will populate ZZ in the 278 file for a response.
278		ISA08		This is the CHC ID used for recognition
278		ISA08		This is the Submitter ID that is specific to the submitter of the request. This ID is assigned to the submitter by CHC.
278		ISA14	0	CHC will always send “0” in this segment for no acknowledgement requested; provider does not need to send a receipt noting that they have received the 278 from CHC.
Functional Group Header				
278		GS01	HR	This notes that the file submitted is a Health Care Claim Status Request (278
278		GS01	HN	This notes that the file submitted is a Health Care Claim Status Notification (278)
278		GS02		This value should equal the ISA06 from the 278 request per recommendation by CHC.
278		GS03		This value should equal theISA08 from the 278 request per recommendation by CHC.
278		GS08	0050100X093A1	This code is from the 278 Addenda dated October 2002 and reflects the value in this Addenda for the GS08 segment.
Detail, Information Source Level				
Provider Name				
278	2100A	NM103		The name of the organization or the last name of the individual that expects to receive information or is receiving information. This is the Payor Name.
278	2100A	NM103		The name of the organization or the last name of the individual that expects to receive information or is receiving information. This is the Payor Name from 278.

Detail, Service Provider Level				
Provider Name				
278	2100C	NM108	FI	Used to identify the type of data value that will appear in the NM109 segment. “FI” denotes the Service Provider Number that NHIC needs to process the request. This will appear in the NM109 segment.
278	2100C	NM109		This is the Federal ID Number (TIN). The TIN must be validated by CHC to be able to process the request appropriately. CHC will only utilize the first 9 characters in this segment.
278	2100C	NM102		In the 278 file, CHC will send back the information as it exists in the CHC adjudication system that matches the dataset sent to CHC by the Transmitter in the NM109 segment of the 278 request. If CHC does not match the data set in the NM109 segment then NM102 will have the same data set populated that was on the 278 request.
278	2100C	NM103		In the 278 file, CHC will send back the information as it exists in the CHC adjudication system that matches the dataset sent to CHC by the Transmitter in the NM109 segment of the 278 request. If CHC does not match the data set in the NM109 segment then NM103 will have the same data set populated that was on the 278 request.
278	2100C	NM104		In the 278 file, CHC will send back the information as it exists in the CHC adjudication system that matches the dataset sent to CHC by the Transmitter in the NM109 segment of the 278 request. If CHC does not match the data set in the NM109 segment then NM104 will have the same data set populated that was on the 278 request.
278	2100C	NM105		In the 278 file, CHC will send back the information as it exists in the CHC adjudication system that matches the dataset sent to CHC by the Transmitter in the NM109 segment of the 278 request. If CHC does not match the data set in the NM109 segment then NM105 will have the same data set populated that was on the 278 request.
278	2100C	NM106		In the 278 file, CHC will send back the information as it exists in the CHC adjudication system that matches the dataset sent to CHC by the Transmitter in the NM109 segment of the 278 request. If CHC does not match the data set in the NM109 segment then NM106 will have the same data set populated that was on the 278 request.
278	2100C	NM107		In the 278 file, CHC will send back the information as it exists in the CHC adjudication system that matches the dataset sent to CHC by the Transmitter in the NM109 segment of the 278 request. If CHC does not match the data set in the NM109 segment then NM107 will have the same data set populated that was on the 278 request.

Detail, Subscriber Level				
Subscriber Name				
278	2100D	NM101	QC	"QC" signifies patient. The 278 response will reflect what is submitted to CHC.
278	2100D	NM102	1	"1" signifies person. The 278 response will reflect what is submitted to CHC
278	2100D	NM108	MI	"MI" is the member Identification Number. If this segment is not populated with "MI" the request will fail at CHC. The 278 response will reflect what is submitted to CHC.
278	2100D	NM109		This is the Medicaid Identification Number (a.k.a. PCN-Patient Control Number) and identifies the subscriber. The 278 response will reflect what is submitted to CHC. CHC will only read postions 1-9 in the 278 of this segment
Claim Submitter Trace Number				
278	2200D	TRN01	1	Transaction Trace Number
278	2200D	TRN02	2	Transaction Trace Number
278	2200D	DTP03		CHC will only read the 2200D Loop for the Claim Service Date and will not use the 2210D Loop (Line Service Date) for this information. The submitter of the 278 is required to verify the date is entered into this segment for CHC to process this request.
Service Line Information				
Service Line Date				
278	2210D	DTP03		CHC will only read the 2200D Loop for the Claim Service Date and will not use the 2210D Loop (Line Service Date) for this information. The submitter of the 278 is required to verify the date is entered into this segment for CHC to process this request.

SECTION 3. CODE SETS

3.1 Explanation of Benefits (EOB) and Explanation of Pending Status (EOPS) Messages

National standard codes must be used to respond to claim status notifications. Providers should refer to the lists of ANSI Claim Adjustment Reason Codes and Remittance Advice Remark Codes published by Washington Publishing Company at the Website www.wpc-edi.com/codes/Codes.asp

3.2 Reference Files

The following information will allow users to find and download the proper reference files from the TexMedNet website.

1. In your browser go to www.texmednet.com.
2. Select "File Libraries" from the icons listed on the screen.
3. Enter your user name and password.
4. Click OK.
5. Select the appropriate Reference File from the list on the left side of the split screen.
For Acute Care, CSHCN (CIDC), and Family Planning select the link to "**REFCD**".
For Long Term Care select the link to "**LTCREFCD**".

GLOSSARY

ANSI X12 276/277 v5010	HIPAA standardized ANSI X12 format for claims status inquiry request and response data.
ANSI X12 278 v5010	HIPAA standardized ANSI X12 transaction format for health care service review.
ANSI X12 835 v5010	HIPAA standardized ANSI X12 transaction format for finalized electronic remittance and status reports.
ANSI X12 837-D v5010	HIPAA standardized ANSI X12 transaction format for dental claims.
ANSI X12 837-I v5010	HIPAA standardized ANSI X12 transaction format for institutional claims.
ANSI X12 837-P v5010	HIPAA standardized ANSI X12 transaction format for professional claims.
Client	Person receiving the services.
CMS	Claim Management System for processing long-term care claims and data.
Compass 21	Medicaid claim processing system for Texas.
CSHCN	**C**hildren with **S**pecial **H**ealth **C**are **N**eeds.
Data Element	Corresponds to a field in data processing terminology. Assigned unique reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data element types are: Nn Numeric (with an assumed number of decimal positions) R Decimal Real Number (including decimal or negative sign) ID Identifier AN Alphanumeric string DT Date TM Time
Data Segment	Corresponds to a record in data processing terminology. Consists of logically related data elements in a defined sequence (defined by X12). Each segment begins with a segment identifier, which is not a data element and one or more related data elements, which are preceded by a data element separator. Each segment ends with a segment terminator.
DED Name	This is the name of segment.
Delimiter	A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.
ECMS	Electronic Commerce Management System
EDI	An acronym for Electronic Data Interchange.
Electronic Data Interchange	The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner, an application file/form, translator (mapper), communications and value added network or value-added service provider.
Element ID	Reference number for a data element see above

Implementation Guides	Documents that provide standardized data requirements and content as the specifications for consistent implementation of a standard transaction set. The Washington Publishing Company publishes HIPAA Implementation Guides on their web site: www.wpc-edi.com.
Interface	The point at which two systems connect to pass data.
Loop ID	A number identifying a group of related segments.
NHIC	National Heritage Insurance Company, a subsidiary of Electronic Data Systems (EDS) contracted by the Texas Department of Health to administer, process, and report Texas Medicaid claims and claim/encounter data.
Procedure Code	Code indicating the service rendered to the patient.
Routing	Separation of data based on specific criteria for subsequent transfer to an internal or external system.
Submitter	Identity which uploads the file electronically or sends the file on paper.
Subscriber	Person who holds the insurance policy. For Medicaid the patient is the subscriber.
Trading Partners	Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.
Translation Software	Commercial computer software that with input instructions converts a standard format to an application format or an application format to a standard format. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt and translation status of a file. Some products also offer translation capability from any format to any format.
X12 Transaction Set	A transaction set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment.
X12N	An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standards for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance.

The information in this Companion Guide may be subject to change. Community Health Choice, Inc. will communicate any significant changes to its contracted providers and update the Companion Guides placed on its Website. If you have any questions, please contact Provider Relations at 713-566-6995 or 1-888-760-2600, email providerrelations@communityhealthchoice.org.