

Companion Document For
ANSI ASC X12N 278 4010A1 (Health Care Services Review) Request
To Blue Cross and Blue Shield of Alabama
For Referral – Professional Only
March 2008

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI ASC X12N 278 implementation guides have been established as the standards of compliance for claim status transactions.

The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI ASC X12N 278 implementation guides. The table contains specific requirements to be used for processing data in the Blue Cross and Blue Shield of Alabama professional claims processing system.

The use of this document is solely for the purpose of clarification. This document, supplements, but does not contradict any requirements in the ANSI ASC X12N implementation guides.

Additional companion documents are available for use with other HIPAA standards.

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ITEM #	LOOP	SEGMENT NAME	LANGUAGE
1.	-----	-----	You must submit incoming 278 transactions using the basic character set as defined in Appendix A of the 278 Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the carrier translator.
2.	-----	-----	The incoming 278 transactions should utilize delimiters from the following list: > (greater than), * (asterisk), ~ (tilde), : (colon), (pipe), and ^ (carrot). Submitting delimiters not supported within this list will cause an interchange (transmission) to be rejected. The usage of these characters within text data elements in the incoming 278 transaction may cause problems with creation of subsequent outbound 278 transactions.
3.	-----	-----	Only loops, segments, and data elements valid for the HIPAA Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
4.	-----	-----	Only loops, segments, and data elements valid for the HIPAA Implementation Guides will be translated. Non-implementation guide data will not be sent for response consideration.
5.	-----	-----	All dates that are submitted on an incoming 278 health care services review request transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the request or the applicable interchange (transmission).
6.	-----	-----	Blue Cross will only process one interchange per request.
7.	-----	-----	Blue Cross will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).
8.	-----	-----	Blue Cross will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).
9.	-----	-----	Blue Cross will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Implementation Guide.

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10.	----	----	Blue Cross will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
11.	----	----	Data Encryption Standard (DES) must be used if the identifiers in the communication header and the interchange (ISA) differ. If encryption is not used, the identifiers in the communication header and the interchange (ISA) must be the same.
12.	----	Communication Header	<u>Socket Interface</u> - User ID should be sent in bytes 17-24 of the header; Vendor ID should be sent in bytes 12-14 of the header. <u>Remote Procedure Call (RPC)</u> - User ID equals 'char prov_nr[9]' in the header; Vendor ID equals 'char vendor_id[4]' in the header.
13.	----	Interchange Control Header	Sender ID is the submitter ID and should be sent in the ISA06 data element. Password should be sent in the ISA04 data element.
14.	----	Interchange Control Header	Use ZZ in ISA07 as the Interchange ID Qualifier.
15.	----	Interchange Control Header	Use 00510BS followed by 8 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA08 as the Interchange Receiver ID.
16.	----	Functional Group Header	Sender ID is the submitter ID and should be sent in the GS02 data element.
17.	----	Functional Group Header	Use 00510BS in GS03 as the Application Receiver's Code.
18.	----	Functional Group Header	Blue Cross will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.
19.	----	Functional Group Header	Use HHMMSSDD as format in the Time data element GS05.
20.	----	Transaction Set Header	Blue Cross will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
21.	2010A	Payer Name	Use 00510 in NM109 (ID Code).
22.	2010B	Provider Name	Use 1P in NM101 (Entity ID Code). Use 1 in NM102 (Entity Type Qualifier). Use XX in NM108 (ID Code Qualifier) and the 10-digit NPI in NM109 (ID Code).

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23.	2000C/ 2000D	Patient Diagnosis	Use BF in HI01-1 (Code List Qualifier Code). Use an ICD-9 diagnosis code in HI01-2 (Diagnosis Code).
24.	2010CA	Subscriber Name	Use MI in NM108 (ID Code Qualifier).
25.	2010E	Service Provider Name	Use SJ in NM101 (Entity ID Code), XX in NM108 (ID Code Qualifier) and the service provider NPI in the NM109 (ID Code). IF the Service Provider is not eligible for a NPI and therefore does not have one, use SJ in NM101 (Entity ID Code) and the REF segment for this loop (see Item 26.)
26.	2010E	Service Provider Supplemental Identification	IF the Service Provider is not eligible for a NPI and therefore does not have one, use 1G (UPIN) or 1J (Facility) or N5 (Professional) in REF01 (Reference ID Qualifier) and the appropriate identifier in REF02 (Reference Identification).
27.	2000F	Health Care Services Review Information	Use SC in UM01 (Request Category Code). Use I (Initial) or 3 (Cancel) in UM02 (Certification Type Code). For an emergency room referral, use 03 (Emergency) in UM06 (Level of Service Code).
28.	2000F	Health Care Services Review Information	Use 03 (emergency) or U (urgent) in UM06 to identify an urgent request. Per the Department of Labor standards, one of these two must be present for the request to be treated as urgent. Urgent requests cannot be processed in the same transaction with non-urgent requests. If a transaction is submitted containing both urgent and non-urgent requests, the transaction will be rejected.
29.	2000F	Service Date	Use RD8 in DTP02 (Date Time Period Format Qualifier).