

**Blue Cross and Blue Shield of Oklahoma
Trading Partner Agreement Companion Document**

278, Health Care Services Review – Request for Review – The Health Insurance Portability and Accountability Act (HIPAA) requires that as covered entities, health insurance payers comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N Implementation Guides have been established as the standards of compliance for electronic transactions. The implementation guides for each HIPAA transaction are available electronically at www.wpc-edi.com. The items within this document are for clarification and are a companion to the execution of the Trading Partner Agreement. The information in this document is subject to change. This companion document supplements, but does not contradict any requirements in the ANSI X12N implementation guides.

As you may be aware, Blue Cross and Blue Shield of Oklahoma does not preauthorize insurance benefits. The reasons for this are many, but primarily have to do with the fact that coverage is a very complex issue that involves much more than medical necessity considerations. A 271 Response indicating the member is eligible for benefits is NOT an automatic acknowledgement of payment for services.

Item No.	Loop ID – Segment Description and Element Name	Ref Desc	HIPAA Page	Plan Preferences
1.	Envelopes – Multiple Transaction types within an Interchange	ISA, GS, GE, IEA	B.8 – B.9	BCBSOK will accept only one HIPAA transaction type for each Batch ID (BID) assigned. Multiple types of HIPAA versions/releases sent to the same Batch ID (BID) will be rejected.
2.	Envelopes – Envelope Segments	ISA, GS, ST, SE, GE, IEA	B.3 – B.10	BCBSOK will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Implementation Guide.
3.	Interchange Control Header Authorization Information Qualifier	ISA01	B.3	'00'
4.	Interchange Control Header Authorization Information	ISA02	B.3	Spaces
5.	Interchange Control Header Security Information Qualifier	ISA03	B.4	'00'
6.	Interchange Control Header Security Information	ISA04	B.4	Spaces
7.	Interchange Control Header Interchange ID Qualifier	ISA05	B.4	'30'
8.	Interchange Control Header Interchange Sender ID	ISA06	B.4	Submitter's Federal Tax ID number (9 Digits, No leading zero)
9.	Interchange Control header Interchange ID Qualifier	ISA07	B.4	'30'
10.	Interchange Control Header Interchange Receiver ID	ISA08	B.5	BCBSOK Federal Tax ID number '730266607' (9 Digits, No leading zero)
11.	Functional Group Header Application Sender's Code	GS02	B.8	Same value as for ISA06
12.	Functional Group Header Application Receiver's Code	GS03	B.8	Same value as for ISA08
13.	2010A - Utilization Management Organization Name	NM108	67	Use 'PI' for Payor Identification
14.	2010A - Utilization Management Organization Name	NM109	67	Use '730266607' (9 Digits, No leading zero)
15.	2010B- Requester Supplemental Identifier	REF02	75	Required to identify the Requesting Provider. Use the Provider Identifier assigned by BCBSOK. This identifier will be used in place of the Requester Identifier (loop 2010B, NM109)
16.	2010B - Requester Address Line	N301	77	Required. This will assist us when we need to contact the Requesting Provider directly.

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17	2010B - Requester City	N401	78	Required. This will assist us when we need to contact the Requesting Provider directly.
18	2010B - Requester State	N402	78	Required. This will assist us when we need to contact the Requesting Provider directly.
19	2010B - Requester Zip Code	N403	78	Required. This will assist us when we need to contact the Requesting Provider directly.
20	2010B – Requester Contact Name	PER02	80	Required if the name of the individual to contact is not already defined or is different than the name within the Requester Name Segment.
21	2010B – Requester Contact Information	PER03 PER04 PER05 PER06	80	A minimum of one valid communication number is required to identify contact person for Requester.
22	2000C – Subscriber Diagnosis	HIXX-1	94	Required when patient is subscriber. In order for proper filing, the diagnosis flagged as the Principal Diagnosis 'BK', must appear as the first diagnosis code in the Subscriber Diagnosis segment. During an extension transaction it is anticipated that a new diagnosis code (not currently associated with the case) may be presented in the transaction. If a new diagnosis code is detected, then the code will be added to the case. To change the designation of a diagnosis that currently exists on the case, to be the primary diagnosis, an extension transaction should be sent with only one diagnosis. This diagnosis should be qualified as the Principal Diagnosis 'BK'. LOINC codes 'LOI' are not supported.
23	2000C – Subscriber Diagnosis	HIXX-4	94	Required if patient is the subscriber and diagnosis is known.
	2000C – Patient Event Tracking Number	TRN01	87	The patient event tracking number 'TRN' can have two (2) loops inbound and three (3) loops outbound. BCBSOK will not generate an outgoing patient event tracking number, so the maximum outbound is two (2) loops.
24	2000C – Additional Patient Information	PWK01	103	At this time, this segment is not supported.
25	2010CA – Subscriber Primary Identifier	NM109	111	Required. This is the Member ID number assigned by BCBSOK and is located on the Member's BCBSOK ID card.
26	2010CA – Subscriber Birth Date	DMG02	113	Required. Subscriber Date of Birth is needed to identify the subscriber/patient.
27	2000D – Patient Event Tracking Number	TRN01	117	The patient event tracking number 'TRN' can have two (2) loops inbound and three (3) loops outbound. BCBSOK will not generate an outgoing patient event tracking number, so the maximum outbound is two (2) loops.
28	2000D – Dependent Diagnosis	HIXX –1	124	Required when patient is dependent. In order for proper filing, the diagnosis flagged as the Principal Diagnosis 'BK', must appear as the first diagnosis code in the Subscriber Diagnosis segment. During an extension transaction it is anticipated that a new diagnosis code (not currently associated with the case) may be presented in the transaction. If a new diagnosis code is detected, then the code will be added to the case. To change the designation of a diagnosis that currently exists on the case, to be the primary diagnosis, an extension transaction should be sent with only one diagnosis. This diagnosis should be qualified as the Principal Diagnosis 'BK'. LOINC codes 'LOI' are not supported.
29	2000D – Additional Patient Information	PWK01	133	At this time, this segment is not supported.
30	2010DA – Dependent Name	NM103 NM104	138	Required to identify the dependent when the dependent is the patient.

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Item No.	Loop ID – Segment Description and Element Name	Ref Desc	HIPAA Page	Plan Preferences
		NM105 NM107		
31	2010DA – Dependent Birth Date	DMG01 DMG02 DMG03	142	Required. Date of Birth is needed to identify the dependent/patient.
32	2010DA – Dependent Relationship	INS02 INS17	144	Required when necessary to identify patient. E.g. Twin Siblings etc.
33	2010E – Service Provider Supplemental Identifier	REF02	153	Required to identify the Service Provider. Use the Provider Identifier assigned by BCBSOK. This identifier will be used in place of the Service Identifier (loop 2010E, NM109)
34	2000F – Service Trace Number	TRN02	165	Required for matching service level response to original request.
35	2000F – Health Care Services Review – Request Category Code	UM01	167	In order for proper filing of inpatient requests, the determination of an inpatient request is made via the UM01 field (Request Category Code) containing a value of 'AR' (Admission Review). When attempting to file an admission length of stay, service loops must be constructed so the first service loop contains the request category code value of 'AR'.
36	2000F – Health Care Services Review – Certification Type Code	UM02	176	<p>Appeals – Appeals processing will allow multiple services to be appealed per transaction. When appealing multiple services within the same transaction, each appealed service may be appealed with a different level of urgency (i.e. different appeal type). However, the appealed services are processed with one transaction/appeal type using the highest level of urgency. As a result, the appeal transaction will be processed and routed based on the greatest level of urgency (where the immediate appeal type has a greater level of urgency than a standard appeal type). Appeals of discharge cases are allowed, but not closed cases. Appeals of closed cases must be handled manually and not through EDI. Excluding 278 transactions for our HMO members, all Appeals will be responded to with a 'CT' for Contact Payer in the 278 Response transaction.</p> <p>Revisions - BCBSOK does not currently support revisions. If requested, a response will be returned with an error code.</p>
37	2000F – Procedures	HI0X-1 HI0X-2	185	<p>The Value "BO" is required in HI0X-1. The HCPCS/CPT code is required in HI0X-2</p> <p>No 'HI' segment should be sent for Admission Review "AR" Requests.</p> <p>Excluding 278 transactions for our HMO members, if multiple procedures are in a single request, each procedure will be separated out into individual requests. E.g. Each 'HI' Procedure Code will be separated out into individual Service Requests, (Loop 2000F) and returned with the submitter's Service Level Trace Number (TRN).</p>
38	2000F – Health Care Services Delivery – Service Unit Count	HSD01 HSD02	204	For Inpatient Requests indicate the service unit count in days 'DY'.