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TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 112
6010.51-M
JANUARY 28, 2011

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: STATE AGENCY BILLING

CONREQ: 14981

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates and clarifies state agency billing requirements.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TRM, Change No. 125.



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ATTACHMENT(S): 5 PAGES
DISTRIBUTION: 6010.51-M

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transaction. *Reference the ASC X12C/005010X231 Implementation Acknowledgement for Health Care Insurance (999) TR3, Appendix C.1, to address implementation use of this transaction.*

- The ANSI ASC X12N TA1 - Interchange Acknowledgment *Segment*.

6.1.2. *Implementation* Acknowledgment

The *implementation* acknowledgment transaction is used to report the results of the syntactical analysis of the functional groups of transaction sets. It is generally the first response to a transaction. (**Exception:** The TA1 will be the first response if there are errors at the interchange or "envelope" level.) *Implementation* acknowledgment transactions report the extent to which the syntax complies with the standards for transaction sets and functional groups. They report on syntax errors that prevented the transaction from being accepted. Version 5010 of the *implementation* acknowledgment transaction does not *cover the semantic meaning of the information encoded in the transaction sets*. The *implementation* acknowledgment transaction may be used to convey both positive and negative acknowledgments. Positive acknowledgments indicate that the transaction was received and is compliant with standard syntax. Negative acknowledgments indicate that the transaction did not comply with standard syntax. Contractors shall develop and implement the capability to generate, send, and receive the following transaction (both positive and negative).

- The ASC X12N 999 - *Implementation* Acknowledgment, Version 5010.

6.1.3. Implementation Guide Syntax And Semantic And Business Edit Acknowledgments

Contractors may use a proprietary acknowledgment to convey implementation guide syntax errors, implementation guide semantic errors, and business edit errors. Alternatively, for claim transactions (ANSI ASC X12N 837 Professional, Institutional, or Dental), the Health Care *Claim Acknowledgment* Transaction Set (ANSI ASC X12N 277CA) may be used to indicate which claims in an 837 batch were accepted into the adjudication system (i.e., which claims passed the front-end edits) and which claims were rejected before entering the adjudication system.

NOTE: In the future, the standards may mandate transactions for acknowledgments to convey standard syntax, implementation guide syntax, implementation guide semantic, and business/application level edit errors. Contractors shall develop and implement the capability to generate and send the following transaction(s).

6.1.3.1. A proprietary acknowledgment containing syntax and semantic errors at the implementation guide level, as well as business/application level edit errors.

6.1.3.2. For 837 claim transactions, contractors may use the Health Care *Claim Acknowledgment* Transaction Set (ANSI ASC X12N 277CA, Version 5010) in place of a proprietary acknowledgment.

6.2. Medicaid Non-Pharmacy Subrogation Claims

6.2.1. When a beneficiary is eligible for both TRICARE and Medicaid, 32 CFR 199.8 establishes TRICARE as the primary payer. Existing TRICARE policy requires contractors to arrange coordination of benefits procedures with the various states to facilitate the flow of claims and to try to achieve a reduction in the amount of effort required to reimburse the states for the funds they erroneously disbursed on behalf of the TRICARE-eligible beneficiary. TRICARE Policy requires that the contractors make disbursements directly to the billing state agency.

6.2.2. Currently, a *subrogation* non-pharmacy claim from a Medicaid State Agency is not a HIPAA covered transaction since the Transaction and Code Sets Rule defines a health care claim or equivalent encounter information transaction as occurring between a provider and a health plan. Since Medicaid State Agencies are not providers, their claims to TRICARE are not covered transactions and need not be in standard format; however, Version 5010 ASC X12 claim standards used for processing institutional, professional and dental claims include the ability to perform Medicaid subrogation. While they are not currently mandated for use under HIPAA, covered entities are not prohibited from using Version 5010 transactions for non-pharmacy Medicaid subrogation transactions between willing trading partners.

- In accordance with existing TRICARE policy, contractors shall coordinate with the Medicaid State Agencies submitting non-pharmacy claims and define the acceptable forms and formats of the claims that are to be used by the Medicaid State Agencies when billing TRICARE. State Agency Billing Agreements shall be modified to reflect the acceptable forms and formats.

NOTE: It is expected that the Secretary, HHS will modify the standard to incorporate Medicaid *subrogation* claims as HIPAA covered transactions sometime in the future. [If this occurs, this section will be modified to reflect the change.]

7.0. ONGOING TRANSACTION TESTING

In the absence of the inclusion of testing requirements in updated HIPAA legislation, contractors shall comply with testing requirements in accordance with the Contracting Officer (CO) direction. At a minimum, testing shall include the following:

7.1. Contractors shall test their capability to create, send, and receive compliant transactions. Contractors shall provide written evidence (e.g., certification from a transaction testing service) of successful testing of their capabilities to create, send, and receive compliant transactions to the contracting offices no later than 60 days prior to the start of services.

- Where failures occur during testing, the contractor shall make necessary corrections and re-test until a successful outcome is achieved.

7.2. Contractors shall test their capability to process standard transactions. This testing shall be "cradle-to-grave" testing from receipt of the transactions, through processing, and completion of all associated functions including creating and transmitting associated response transactions. Testing involving the receipt and processing of claims transactions shall also include the submission to and acceptance by the TMA of *TRICARE Encounter Data*

(TED) records and the creation of contract compliant paper Explanation Of Benefits (EOB). It is expected that the contractors shall complete "cradle-to-grave" testing no later than 30 days prior to the start of services.

8.0. MISCELLANEOUS REQUIREMENTS

8.1. Paper Transactions

8.1.1. Contractors shall continue to accept and process paper-based transactions.

8.1.2. Contractors may pay claims via electronic funds transfer or by paper check. The ASC X12N 835 Health Care Claim Payment/Advice transaction contains two parts, a mechanism for the transfer of dollars and one for the transfer of information about the claim payment. These two parts may be sent separately. The 835 Implementation Guide allows payment to be sent in a number of different ways, including by check and electronic funds transfer. Contractors must be able to send the remittance advice portion electronically but may continue to send payment via check.

8.1.3. Current applicable requirements for the processing of paper-based and electronic media transactions, such as claims splitting, forwarding out-of-jurisdiction claims, generating and sending EOBs to beneficiaries and providers, etc., apply to the processing of electronic transactions.

8.2. Attendance At Designated Standards Maintenance Organization (DSMO) Meetings

8.2.1. Contractors shall regularly send representatives to the following separate DSMO meetings: the ANSI X12 Trimester Meetings, and the Health Level Seven (HL7) Trimester Meetings. Each MCSC shall send one representative to each DSMO Trimester meeting. A contractor may elect to send representatives from their claims processing subcontractor(s) in place of a contractor representative. Every effort should be made to have the same representatives attend each meeting for continuity purposes. The team lead will be the TMA representative in attendance.

8.2.2. Representatives shall be knowledgeable of TRICARE program requirements, and of their own administrative and claims processing systems. Prior to attending a DSMO meeting, the representatives shall identify from within their own organizations any issues that need to be addressed at the DSMO meeting. The representatives shall inform the TMA representative (team lead) of the issues at least one week prior to the meetings.

8.2.3. Contractor representatives shall attend the DSMO meetings as exclusive advocates for TRICARE business needs and should not divide their participation and attention with any commercial business needs and concerns. Contractor representatives shall attend and participate in workgroup and full committee meetings. They shall work within the DSMOs to incorporate into the standards and implementation guides any data elements, code values, etc., that may be required to conduct current and future TRICARE business. The representatives shall also work to prevent removal of any existing data elements, code values, etc., from the standards and implementation guides that are necessary to conduct current and future TRICARE business.

8.2.4. When attending the DSMO meetings, contractor representatives shall work as a team and collaborate with other government and DoD/TRICARE representatives. Contractor representatives shall register under the DoD/Health Affairs (HA) DSMO memberships. Contractor representatives are responsible for taking proposed changes through the processes necessary for adoption within the DSMOs. They are responsible for tracking and reporting on the status of each proposed change as it progresses through the process.

8.2.5. Contractor representatives *shall keep* TMA apprised of any additions to the standards that must be made to accommodate TRICARE business needs and of any proposed changes to existing standards and implementation guides. Following a DSMO meeting, each representative attendee shall prepare a summary report that includes, at a minimum; the workgroup and full committee meetings attended, a brief description of the content of the meetings, the status of any changes in progress, and any problems or information of which the Government/TMA should be aware. Each representative shall submit their reports to the TMA team lead within 10 work days following the DSMO meetings.

8.3. Provider Marketing

8.3.1. Contractors shall encourage providers to utilize electronic transactions only through marketing and provider education vehicles permitted within existing contract limitations and requirements. No additional or special marketing or provider education campaigns are required. Marketing efforts shall educate providers as to the cost and efficiency benefits that can be realized through adoption and utilization of electronic transactions.

8.3.2. Contractors shall assist and work with providers, who wish to exchange electronic transactions, to establish trading partner agreements and connectivity with their systems and to implement the transactions in a timely manner. Contractors are not required by the government to perfect transactions on behalf of trading partners.

8.4. Data Retention And Audit Requirements

8.4.1. All HIPAA-covered electronic transaction data, including eligibility and claims status transaction data, shall be stored until the end of the calendar year in which it was received plus an additional six years. Where a contractor is directed by TMA to freeze records, electronic transaction data shall be included and shall be retained until otherwise directed by TMA.

8.4.2. Contractors shall generate transaction histories covering a period of up to seven years upon request by TMA in a text format (delimited text format for table reports) that is able to be imported, read, edited, and printed by Microsoft Word (Microsoft Excel for table reports). Contractors shall *have the ability* to generate transaction histories on paper. Transaction histories shall include at a minimum, the transaction name or type, the dates the transaction was sent or received and the identity of the sender and receiver. Transaction histories must be able to be read and understood by a person.

8.4.3. Transaction data is subject to audit by TMA, TROs, DoD, HHS, and other authorized government personnel. Contractors shall *have the ability* to retrieve and produce

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all electronic transaction data upon request from TMA (for up to seven years, or longer if the data is being retained pursuant to a records freeze), to include reasons for transaction rejections.

