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TRICARE
MANAGEMENT ACTIVITY

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CHANGE 45
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to 6010.51-M, reissued August 2002.

CHANGE TITLE: REVISED NATIONAL PROVIDER IDENTIFIER (NPI)

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change implements National Provider Identifier (NPI) requirements in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Administration Simplification Provision, 45 CFR 162, NPI. The NPI Final Rule, dated January 23, 2004, effective date May 23, 2005, mandates that a standard identifier be used for the identification of providers in HIPAA-compliant electronic standard transactions. Compliance is mandated as of May 23, 2007.

EFFECTIVE DATE: May 23, 2007.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

Evie Lammle
Director, Program Requirements Division

ATTACHMENT(S): 25 PAGES
DISTRIBUTION: 6010.51-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

CHANGE 45
6010.51-M
MARCH 9, 2007

REMOVE PAGE(S)

CHAPTER 8

Section 2, pages 1 through 8

CHAPTER 21

Table of Contents, page i

★ ★ ★ ★ ★ ★

Addendum A, pages 11 through 18

INSERT PAGE(S)

Section 2, pages 1 through 8

Table of Contents, page i

Section 4, pages 1 through 8

Addendum A, pages 11 through 18

JURISDICTION

In the early stages of claims review, the contractor shall determine that claims received are within its contractual jurisdiction using the criteria below. Contractor jurisdictions are provided in the TRICARE Contractor Address List issued by *the TRICARE Management Activity (TMA)*. This address list also can be found on the TMA Home Page at <http://www.tricare.mil>, then click on Claims Information.

1.0. PRIME ENROLLEES

When a beneficiary is enrolled in TRICARE Prime, contractor jurisdiction is determined by the beneficiary's regional enrollment. The contractor processes all claims for the enrollee no matter where the enrollee receives services. For information on claims for relocating Prime enrollees, refer to Chapter 6, Section 2, Enrollment Portability. When a beneficiary's enrollment changes from one region to another during a hospital stay, the contractor with jurisdiction on the date of admission shall process and pay the entire *Diagnostic Related Group (DRG)* claim, including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short stay outliers cases, and for professional claims that are date-driven, the contractor with the jurisdiction on the date of service shall process and pay the claim.

NOTE: All dental claims for *Active Duty Service Members (ADSMs)* enrolled in the TRICARE Prime Remote (*TPR*) Program shall be forwarded to the appropriate Service Point Of Contact (*SPOC*) listed in Chapter 18, Addendum B.

2.0. ALL OTHER TRICARE BENEFICIARIES

For a beneficiary who is not enrolled in TRICARE Prime, the contractor with jurisdiction for the beneficiary's claim address shall process the claim no matter where the beneficiary receives services. This includes *Continued Health Care Benefits Program (CHCBP)* claims and claims from U.S. Government medical facilities other than those of the Uniformed Services (e.g., a claim for emergency care provided by a Veterans Administration (*VA*) facility or a facility under the Indian Health Service (*IHS*), Public Health Services (*PHS*)). Claims for beneficiaries residing outside the United States shall be processed in accordance with the TRICARE Policy Manual (*TPM*), Chapter 12. For inpatient claims paid under the DRG-based payment system, the contractor with jurisdiction for the beneficiary's claim address, on the date of admission, shall process and pay the entire DRG claim including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short-stay outlier cases, and for professional claims that are date-driven, the contractor with jurisdiction for the beneficiary's claim address on the date of service, shall process and pay the claim.

3.0. SUPPLYING OUT-OF-AREA PROVIDER INFORMATION

For out of area claims the regional contractor responsible for certifying providers and developing pricing data for the region where the services were provided shall supply provider and pricing information (both institutional and non-institutional) to the contractor responsible for processing the claims. The contractor shall respond within five workdays after receipt of such requests and shall designate a point of contact for this purpose. The contractor shall follow the procedures below in requesting and providing information. Responses to such requests shall include only that information not available in the requester's own records or in TMA-provided records. The response shall verify whether or not the provider is a TRICARE-authorized provider and whether or not the provider is a network provider. The response shall also include the appropriate pricing of the services/ supplies as well as specific data needed to complete contractor records and *TRICARE Encounter Data* (TED) submissions to the TMA.

3.1. Procedures For Contractor Coordination On Out-Of-Jurisdiction Providers

Contractors subject to the requirements of the TRICARE Systems Manual (*TSM*) who are responsible for processing claims for care provided outside of their provider certification jurisdiction shall first search available provider files, including the TMA-supplied copy of the TRICARE centralized provider file (to be provided at least weekly), to determine provider certification status, obtain related provider information, and determine if the certifying contractor has submitted a TRICARE Encounter Provider Record (TEPRV) for the out-of-area provider.

3.2. File Search Unsuccessful

If the file search is unsuccessful, the following procedures apply:

3.2.1. The servicing (claims processing) contractor shall request provider information from the certifying contractor.

3.2.2. Each contractor shall designate a point of contact as specified in paragraph 1.0. who shall be responsible for initiating actions related to such requests and ensuring these actions are timely and well documented.

3.2.3. The certifying contractor shall respond within five workdays of the request with either:

3.2.3.1. Complete provider information for the servicing contractor to process the claim and submit TED in situations when a TEPRV has already been accepted by TMA or,

3.2.3.2. The information that a TEPRV for the provider in question has not been submitted to or accepted by TMA and one of the following situations exist:

- The certifying contractor has sufficient documentation (including the provider's *Tax Identification Number* (TIN)) to complete the certification process and determine the provider's TRICARE status; or

- The certifying contractor does not have sufficient documentation to determine the provider's status and complete the certification process; or
- The certifying contractor has sufficient information to determine that the provider does not meet TRICARE certification requirements without going through the certification process; or
- The situations above apply, but the certifying contractor is not subject to the requirements of the *TSM*.

3.3. TEPRV Submissions

3.3.1. Since the servicing contractor will be unable to complete TED processing until a TEPRV is accepted by TMA, a coordinated effort is required between the servicing contractor and the certifying contractor in the above situations. The certifying contractor is responsible for ensuring the TEPRV is accepted by TMA before supplying the provider information indicated. Contractors shall not delay submitting TEPRVs for providers who have requested certification and such certification has been granted or denied, solely because the provider has not yet submitted a TRICARE claim. When the TEPRV is accepted, the certifying contractor shall notify the servicing contractor of this within two workdays of its acceptance and supply the provider information. Following are procedures and time frames to facilitate this coordination.

3.3.2. If the certifying contractor has completed its provider certification process but has yet to submit the TEPRV (or the TEPRV has not passed TMA edits), the certifying contractor shall submit (or resubmit) the TEPRV within one workday of contact by the servicing contractor and notify the servicing contractor within two calendar weeks following the initial contact, of the TEPRV submission action taken and whether it was accepted.

3.3.3. If the certifying contractor does not have sufficient documentation to complete the certification process and submit a TEPRV, the certifying contractor shall initiate (or follow up on) the certification process within two workdays of the initial contact by the servicing contractor. If it is necessary to obtain documentation from the provider, the certifying contractor shall allow no longer than a two calendar week suspense from the date of its request.

3.3.4. Upon determination that the documentation is complete, the certifying contractor shall complete the certification process, submit the TEPRV, and notify the servicing contractor within one additional calendar week following completion of the certification process (i.e., within three weeks of the initial contact by the servicing contractor). The certifying contractor shall also notify the provider of the certification determination and of procedures for contacting the certifying contractor in the future regarding provider-related (non-claim) matters (e.g., address changes).

3.3.5. If the certifying contractor is unable to complete the certification process within three calendar weeks following the initial contact, it shall submit the TEPRV and notify the servicing contractor within four calendar weeks following the initial contact.

3.3.6. If the certifying contractor has substantial evidence (e.g., state licensure listing) that the provider meets TRICARE certification requirements, it shall consider the provider certified and so inform the servicing contractor one work day after acceptance.

3.3.7. If the certifying contractor does not have substantial evidence that the provider meets TRICARE certification requirements, it shall not consider the provider to be certified. The servicing contractor shall deny the claim using an appropriate *Explanation of Benefits* (EOB) message.

3.3.8. In either of the above cases, if the certifying contractor does not have the provider's TIN, it shall submit the TEPRV with a contractor Assigned Provider Number (APN) as described in the *TSM*, Chapter 2, Section 2.10, Provider Taxpayer Number, and provide this number to the servicing contractor. The servicing contractor shall issue payment only to the beneficiary in this case if the claim is otherwise payable (even in the unlikely event that the provider is participating).

3.3.9. If, at the time of the servicing contractor's initial contact, the certifying contractor is able to determine that the provider does not meet the TRICARE certification requirements without going through the certification process, it shall submit the TEPRV and notify the servicing contractor within two calendar weeks of the initial contact. If the provider's TIN is not known, the certifying contractor shall assign an APN. The servicing contractor shall deny the claim using an appropriate EOB message.

3.3.10. If the certifying contractor is not subject to the requirements of the *TSM*, the servicing contractor will assign the provider *sub-identifier* (sub-ID) and create the TEPRV. The certifying contractor shall provide the servicing contractor with the minimum provider information listed below, within two workdays of the initial contact by the servicing contractor if the certification process has been completed or if a determination can be made that the provider does not meet the certification requirements without going through the process. If it has not been completed, the servicing contractor shall be so notified within two workdays of the initial contact and the procedures and time frames above shall be followed.

3.3.11. The servicing contractor shall notify the TMA Contracting Officer's Representative (*COR*) if the certifying contractor does not provide the required provider information and notification of the TEPRV's acceptance by TMA within 35 calendar days from the time of the initial contact.

3.4. Provider Data

The minimum provider data to be provided by the certifying contractor is the provider's certification status including the reason a provider is not certified if such is the case, any special prepayment review status, and the following data:

3.4.1. Provider Taxpayer Number, *APN*, or *National Provider Identifier (NPI)*, as appropriate.

3.4.2. Provider Sub-ID (*not required for NPI*). *Provider Sub-Identifier* may need to be assigned by the servicing contractor if the certifying contractor is not subject to the requirements of the *TSM*.

- 3.4.3. Provider Contract Affiliation Code.
- 3.4.4. Provider street address.
- 3.4.5. Provider "pay to" address.
- 3.4.6. Provider State or Country.
- 3.4.7. Provider Zip Code.
- 3.4.8. Provider Specialty (non-institutional providers).
- 3.4.9. Type of Institution (institutional providers).
- 3.4.10. Type of reimbursement applicable (DRG, MHPD, etc.).
- 3.4.11. Per diem reimbursement amount, if applicable.
- 3.4.12. *Indirect Medical Education* (IDME) factor (where applicable), Area Wage Index (DRG).
- 3.4.13. Provider Acceptance Date.
- 3.4.14. Provider Termination Date.
- 3.4.15. Record Effective Date.
- 3.4.16. The certifying contractor shall provide additional data upon request of the servicing contractor or TMA to meet internal processing, prepayment review, or file requirements or, to create a TEPRV when the certifying contractor is not under the requirements of the *TSM*.

3.5. Maintenance Of TEPRV With An APN

In all cases when an APN is assigned, the certifying contractor shall attempt to obtain the provider's actual TIN. Within ten workdays of receipt of the provider's TIN, the certifying contractor who is under the requirements of the *TSM* shall inactivate the APN TEPRV and add the TEPRV with the provider's TIN regardless of whether the provider meets TRICARE certification requirements.

All APNs must be associated with an NPI for providers who meet the Health and Human Services (HHS) definition of a covered entity and submit Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic standard transactions or who otherwise obtain an NPI. Guidance for submitting the NPI on TEPRV records will be provided in a future order.

3.6. Provider Correspondence

Any provider correspondence which the servicing contractor forwards for the certifying contractor's action or information shall be sent directly to the certifying

contractor's point of contact to avoid misrouting. Within one week of receipt, the servicing contractor shall forward for the certifying contractor's action any correspondence or other documentation received which indicates the need to perform a provider file transaction. This includes, but is not limited to, such transactions as address changes, adding or deleting members of clinics or group practices, or changing a provider's TIN.

3.7. Provider Certification Appeals

3.7.1. Requests for reconsideration of an contractor's adverse determination of a provider's TRICARE certification status are processed by the certifying contractor. Any such requests received by the servicing contractor are to be forwarded to the certifying contractor within five workdays of receipt and the appealing party notified of this action and the reason for the transfer. The certifying contractor shall follow standard appeal procedures including aging the appeal from the date of receipt by the certifying contractor, except that, if the reconsideration decision is favorable, the provider shall be notified to resubmit any claims denied for lack of TRICARE certification to the servicing contractor with a copy of the reconsideration response. In this case, the certifying contractor shall ensure a TEPRV for this provider is accepted by TMA within one calendar week from the date of the appeal decision.

3.7.2. The servicing contractor shall forward to the certifying contractor within five workdays of receipt any provider requests for review of claims denied because the certifying contractor was unable to complete the certification process. The servicing contractor shall notify the provider of the transfer with an explanation of the requirement to complete the certification process with the certifying contractor. Upon receipt of the provider's request, the certifying contractor shall follow its regular TRICARE provider certification procedures. In this case, no basis for an appeal exists. If the provider is determined to meet the certification requirements, the special provider notification and TEPRV submittal requirements apply.

4.0. OUT-OF-JURISDICTION CLAIMS

The contractor shall handle all claims involving billings outside its jurisdiction (including those to be processed by TMA, and dental claims to be processed by the SPOCs listed in Chapter 18, Addendum B under the TPR Program) as follows:

4.1. Totally Out-Of-Jurisdiction

When a contractor receives a claim with no services or supplies within its jurisdiction, it shall clearly indicate the original date of receipt on the claim. The contractor shall then forward the claim and supporting documentation to the appropriate contractor(s) within 72 hours of identifying it as being out-of-jurisdiction. All contractors shall include current information on the beneficiary and family deductible and catastrophic loss amounts, if any, shown as accumulated on the history file. The transferring contractor shall also inform the claimant of the action taken and provide the address of the contractor to which the claim was forwarded. (See Chapter 8, Addendum A, Figure 8-A-2 for suggested language.)

4.2. Partially Out-Of-Jurisdiction

When a contractor receives a claim for services or supplies both within and outside its jurisdiction before processing the services or supplies within its jurisdiction, and within 72 hours of identifying the out-of-jurisdiction items, the contractor shall:

- Draw lines through the in-jurisdiction items.
- Ensure the original date of receipt is clearly indicated on the claim
- Send a copy of the claim and all supporting documents to the appropriate contractor(s).
- The contractor shall include current information on the beneficiary and family deductible and catastrophic loss amounts accumulated.
- If more than one other contractor is involved, the transferring contractor shall provide each the name(s) of the other(s). The transferring contractor shall notify the claimant of the action taken and provide the address(es) of the contractor(s) to which the claim was forwarded. In addition, the contractor shall briefly explain the potential for application of excessive deductible for outpatient services due to the involvement of more than one contractor in the processing of the one claim and the procedures to follow should this occur. (See Chapter 8, Addendum A, Figure 8-A-3 for suggested language.)

5.0. NON-TRICARE CLAIMS

The contractor shall return claims submitted on other than approved TRICARE claim forms to the sender or transfer to other lines of business, if appropriate.

5.1. *Civilian Health and Medical Program of the Department of Veteran Affairs* (CHAMPVA) Claims

When a claim is identified as a CHAMPVA claim, the contractor shall return the claim to the sender with a letter advising them that the CHAMPVA Program's toll-free telephone number 1-800-733-8387, and instruct them to send the claim and all future CHAMPVA claims to:

Health Administration Center
CHAMPVA Program
P.O. Box 65024
Denver, Colorado 80206-9024

5.2. Veterans Claims

If a claim is received for care of a veteran and there is evidence the care was ordered by a VA physician, the claim, with a letter of explanation, shall be sent to the VA institution from which the order came. The claimant must also be sent a copy of the letter of explanation. If there is no clear indication that the VA ordered the care, return the claim to the sender with

an explanation that the veteran is not eligible under TRICARE and that the care ordered by the VA should be billed to the VA.

5.3. Claims For Parents, Parents-In-Law, Grandchildren, And Others

On occasion, a claim may be received for care of a parent or parent-in-law, a grandchild, or other ineligible relative of a TRICARE sponsor. Return the claim to the claimant with a brief explanation that such persons are not eligible for TRICARE benefits.

5.4. Pharmacy Claims

The contractor shall forward all retail pharmacy claims to the pharmacy contractor within 72 hours of identifying it as being out-of-jurisdiction.

5.5. Medicare Dual Eligibles

The contractor shall forward all claims from beneficiaries who have eligibility for both Medicare and TRICARE to the TRICARE Dual Eligible Fiscal Intermediary Contract (*TDEFIC*) contractor within 72 hours of identifying it as being out-of-jurisdiction.

6.0. CONTINUED TRICARE COVERAGE FOR DUAL ELIGIBLE BENEFICIARIES UNDER AGE 65

7.0. The National Defense Authorization Act (*NDAA*) for FY 2005 has extended TRICARE coverage to those individuals who, because of disability or end stage renal disease, are eligible for Medicare Part A but did not obtain Part B. The new legislation provides the authority to waive collection of prior payments and to continue TRICARE coverage of benefits for these individuals for a period of July 1, 1999 and ending on December 31, 2004. In a future Centers for Medicare and Medicaid Services (CMS) Special Enrollment Period, these individuals without Part B will automatically be enrolled in Part B unless they specifically opt out. If an individual does disenroll from Medicare Part B, he or she will lose all TRICARE coverage effective with the date of disenrollment. However, individuals will be given an opportunity to change the effective date of Medicare Part B enrollment to any month in 2004. Effective January 1, 2005, any TRICARE beneficiary under the age of 65, except for dependents of active duty members, who are or become eligible for Medicare and do not purchase Part B, will lose TRICARE coverage.

8.0. On a date to be announced, *Defense Manpower Data Center* (DMDC) will load the most current Medicare status for all beneficiaries under age 65. The DEERS query response for Other Government Programs (OGP) will list the Medicare entitlement and reflect either Part A or both Part A and Part B effective dates. DMDC has temporarily modified the "benefits rules" within DEERS during this waiver period to show these beneficiaries with Part A or gaps in effective dates between Part A and Part B as TRICARE eligible. Treat these individuals as fully TRICARE dual eligible even if there is a gap in effective dates between Part A and Part B and accept the Health Care Delivery Plan (*HCDP*) returned from DEERS.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

SECTION	SUBJECT
1	GENERAL 1.0. Purpose 2.0. Background
2	STANDARDS FOR ELECTRONIC TRANSACTIONS FINAL RULE 1.0. Background And Provisions 2.0. TRICARE Objectives 3.0. Contractor Relationships To The TRICARE Health Plan 4.0. Transaction Requirements For TRICARE Contractors 5.0. Trading Partner Agreements 6.0. Additional Non-HIPAA Transactions Required 7.0. Transaction Testing 8.0. Miscellaneous Requirements
3	PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION 1.0. Background And Applicability 2.0. Contractor Responsibilities
4	HEALTH AND HUMAN SERVICES (HHS) STANDARD UNIQUE HEALTH IDENTIFIER FOR HEALTH CARE PROVIDERS FINAL RULE 1.0. <i>Background And Provisions</i> 2.0. <i>Transition Of Current Provider Identifiers To NPIs</i> 3.0. <i>Providers</i> 4.0. <i>Contractor Responsibilities</i> FIGURE 21-4-1 <i>Professional (Individual/Type 1) Provider</i> FIGURE 21-4-2 <i>Group Practice/Clinic (Organizational/Type 2) Provider</i> FIGURE 21-4-3 <i>Group Practice/Clinic With Multiple Individual Providers</i> FIGURE 21-4-4 <i>Institutional Provider With Subparts Enumerated</i> FIGURE 21-4-5 <i>Institutional Provider Without Subparts Enumerated</i> 5.0. <i>Testing</i>
ADDENDUM A	HIPAA DEFINITIONS
ADDENDUM B	ADDITIONAL SUPPORTING INFORMATION PERTAINING TO THE TRANSACTION AND CODE SETS FINAL RULE
ADDENDUM C	REPORTS FIGURE 21-C-1 <i>Complaint Report (Sample)</i> FIGURE 21-C-2 <i>Annual Risk Assessment Letter Of Assurance (Sample)</i>

CHAPTER 21
SECTION 4

**HEALTH AND HUMAN SERVICES (HHS) STANDARD UNIQUE
HEALTH IDENTIFIER FOR HEALTH CARE PROVIDERS FINAL
RULE**

1.0. BACKGROUND AND PROVISIONS

On January 23, 2004, Health and Human Services (HHS) published the Final Rule establishing the National Provider Identifier (NPI) as the standard unique health identifier for health care providers (both individuals and organizations). The implementation specifications contained in the rule must be met by "covered entities" which include health plans, clearinghouses, and providers who submit Health Insurance Portability and Accountability Act (HIPAA)-compliant standard electronic transactions, as defined by the HIPAA regulations at 45 CFR 160.103. As of May 23, 2005, health care providers began applying for the required NPI.

The NPI is a 10-digit identifier, with an International Standard Organization (ISO) standard check-digit in the 10th position. It is to be used as the primary identifier in all standard HIPAA-compliant electronic transactions. The NPI contains no embedded information about the health care provider. It is the intent of the Final Rule that individual (Entity Type 1) health care providers receive only one NPI. The NPI Final Rule sets the circumstances under which a covered organization (Entity Type 2) provider may designate subparts for NPI assignment. (See paragraph 3.0. for Entity Type definitions and paragraph 3.2. for Subpart Enumeration.) The NPI assigned to each provider will serve as a permanent identifier and will only be inactivated upon death, cases of fraud or dissolution of the health care provider.

HHS will manage the National Plan and Provider Enumeration System (NPPES) for the processing of NPI application requests and NPI issuance after May 23, 2005, the effective date of the Final Rule.

In addition to the effective date of the NPI, the Final Rule requires compliance no later than May 23, 2007. The Final Rule stipulates that covered entities (except small health plans) must obtain an NPI and use the NPI in standard transactions no later than May 23, 2007. Small health plans must comply no later than May 23, 2008.

2.0. TRANSITION OF CURRENT PROVIDER IDENTIFIERS TO NPIS

In order to facilitate the necessary actions required for the transition of the identification of providers from current TRICARE Management Activity (TMA) Provider Numbers to NPIS, TMA is supporting a period during which contractors will accommodate the submission of HIPAA-compliant electronic standard transactions with both the current TMA Provider Number and the NPI. This will be referred to as the "Dual Use Period." TMA expects this Dual Use Period to mirror the recommendations of the Workgroup for Electronic Data Interchange (WEDI) White Paper, "Dual Use of NPI and Legacy Identifiers," Version 2.0, dated December 5, 2005 and may begin no later than (NLT) 90 days prior to the Final Rule implementation date or upon direction of the Contracting

Officer (CO). The White Paper is based on review and analysis of the current version of the Implementation Guides for each of the HIPAA-compliant electronic standard transactions. The Implementation Guides for each transaction, in effect as of December 5, 2005, identify the fields currently existing within each transaction that are to be used for the identification of a provider. The Implementation Guides indicate the segments that will be used to capture the NPI and the Tax ID or the legacy (current TMA Provider Number) identifier for the provider. During the Dual Use Period contractors will use the legacy provider identifier, submitted in the segment identified in the transaction Implementation Guide for the adjudication of the transaction, ignoring the segment containing the NPI.

At the end of the dual use period, contractors will use the segment required by the transaction Implementation Guide, in the appropriate loop of each transaction, to capture the NPI for the provider and use the NPI for the identification of the provider and claims processing.

3.0. PROVIDERS

HHS defines a health care provider in Section 1861(u) of the Act, 42 United States Code (USC) 1395X(u), as a provider of medical or health services as defined in section 1861(s) of the Act, 42 USC 1395X(s). Generally, a provider is a person or organization who furnishes, bills, or is paid for health care in the normal course of doing business.

For the purposes of the applicability of the rule to TMA, see the TRICARE Policy Manual (TPM), Chapter 11, Section 1.1, for a listing of authorized provider types.

Health Care Providers are defined in two categories for enumeration purposes:

- *Entity Type 1--Individual. Includes, but is not limited to, those human beings who provide care such as, physicians, nurse practitioners, dentists, chiropractors, pharmacists and physical therapists.*
- *Entity Type 2--Organizational. Includes, but is not limited to, non-person providers such as hospitals, home health agencies, clinics, laboratories, suppliers of durable medical equipment, pharmacies, and groups.*

3.1. Foreign Providers

3.1.1. *A foreign provider is defined as a provider who is not a citizen of the United States, regardless of the country in which the provider is practicing. Foreign providers may be authorized TRICARE providers, however, they are not required to obtain an NPI (due to limited ability to comply with the application requirements), but may choose to do so voluntarily. Electronic transactions (e.g., claims transactions) submitted by foreign providers for adjudication may be submitted using legacy identifiers for provider identification purposes, however, if a foreign provider obtains an NPI, they are encouraged to use the NPI as the primary provider identifier on the electronic transaction.*

3.1.2. *Providers who are citizens of the U.S., practicing outside the U.S. (e.g., Puerto Rico), are not considered to be "foreign providers". If the provider practicing outside the U.S. is a U.S. citizen and meets the HHS definition of a "covered entity", the provider is required to obtain an NPI for the*

submission of HIPAA-compliant electronic standard transactions and comply with the Final Rule. Electronic transactions submitted by "covered entities", who are U.S. citizens, that are not HIPAA-compliant must be denied as appropriate.

3.2. Subpart Enumeration

Subpart Enumeration is the responsibility of the Organizational Provider. In accordance with the Final Rule, Organizational Providers will determine to what extent subpart enumeration is required and identify which of the subparts, if any, of their organizational entity will be identified via a separate enumerator. The Organizational Provider will also determine how the various enumerators obtained will be used for billing purposes.

4.0. CONTRACTOR RESPONSIBILITIES

4.1. *Contractors shall comply with the Department of Health and Human Services Standard for Unique Health Identifier for Health Care Providers Final Rule.*

4.2. *Contractors shall accept NPIs when submitted by providers and use the NPI as the primary identifier to identify health care providers in all HIPAA-compliant electronic standard transactions in accordance with the transaction Implementation Guide. It is noted that during the dual use period, in addition to the NPI, additional identifiers may be used.*

4.3. *Contractors shall deny all claims transactions that do not meet the requirements of the Final Rule.*

4.4. *Since the National Uniform Billing Committee (NUBC) and the National Uniform Claims Committee (NUCC) have modified the UB04 and the Centers for Medicare and Medicaid Services (CMS) 1500 to accommodate the use of the NPI on the paper forms, contractors are required to accept and use the NPI if submitted on the paper form for provider identification and claims adjudication.*

4.5. *Contractors shall verify NPIs using the check digit algorithm in accordance with the Final Rule, 45 CFR Part 162.*

4.6. *Contractors shall maintain the NPI in their internal provider file. Upon direction of the CO and future revision of the TRICARE Systems Manual (TSM), Chapter 2 to address the NPI requirements for the TRICARE Encounter Provider (TEPRV) records and TRICARE Encounter Data (TED) record, contractors shall create and submit to TMA a new TRICARE Encounter Provider (TEPRV) record when a provider submits their NPI to the contractor.*

- *Type 1 NPI for professional providers.*
- *Type 2 NPI for organizational providers.*
- *Type 2 NPI for subparts of organizational providers that have been separately enumerated, e.g., different NPIs for different departments within an institution, the contractor shall list the Type 2 NPI for each subpart identified by the provider.*

4.7. *Contractors shall map NPIs for providers to TMA Provider Number(s) and subidentifier(s).*

4.8. *Contractors shall:*

4.8.1. *Covered Individual (Type 1) Health Care Providers*

- *Ensure HIPAA transactions received identify the provider's NPI on all HIPAA-compliant electronic standard transactions in accordance with the Implementation Guide for the Transaction.*
- *Ensure electronic transactions submitted by business associates of the individual provider use their NPIs and NPIs of other health care providers and subparts appropriately for the submission of HIPAA-compliant electronic standard transactions in accordance with the Implementation Guide for the Transaction.*

4.8.2. *Covered Organizational (Type 2) Health Care Providers*

- *Ensure that transactions submitted by the organizational entity and/or its subparts use the NPI on HIPAA-compliant electronic standard transactions.*
- *Ensure that transactions submitted by the organizational subparts comply with the NPI implementation specifications.*
- *Ensure that business associates of the organizational entity and/or its subparts use their NPIs and NPIs of other health care providers and subparts appropriately for the submission of HIPAA-compliant electronic standard transactions.*

4.9. *Compliance Date*

As of May 23, 2007, contractors must be able to process HIPAA-compliant standard electronic transactions submitted with an NPI as the primary provider identifier. Contractors shall deny all transactions that do not meet the requirements of the Final Rule. In addition, contractors must also be able to process transactions submitted with the legacy identifiers for atypical providers or other non-covered entities. If CMS grants an extension to the dual use period or any other changes to the transition period, the contractors will be notified by CO letter.

4.10. *Application Of NPI To TMA Processes And Systems*

Upon full implementation of the Final Rule, the NPI shall be used as the primary provider identifier for all TRICARE authorized providers who meet the HHS definition of "covered entities" and submit HIPAA-compliant electronic standard transactions. The contractor shall also accept the NPI as the primary identifier on paper claims from providers who obtain an NPI and use it.

The NPI shall be used, as appropriate, for the identification of providers in the Defense Enrollment and Eligibility Reporting System (DEERS).

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002
 CHAPTER 21, SECTION 4
 HEALTH AND HUMAN SERVICES (HHS) STANDARD UNIQUE HEALTH IDENTIFIER FOR
 HEALTH CARE PROVIDERS FINAL RULE

Upon direction of the CO and future revision of the TSM, Chapter 2, the NPI shall be used as the primary provider identifier for TEPRV and TED records, for health care providers who meet the HHS definition of covered entity and submit HIPAA-compliant electronic standard transactions. The NPI will also be used as the primary provider identifier on the TEPRV and TED record for providers who obtain an NPI and submit paper claim forms.

TED records will identify both the individual and/or organizational provider NPI as appropriate. For providers who are part of a group or clinic practice, the TED record will reflect the NPI for the group or clinic as well as the NPI of the individual provider. TED records submitted for Institutional claims must include the NPI for the Organizational (Type 2) entity. Individual NPIs shall not be submitted on institutional TED records.

At a date to be determined, NPI shall be used for the identification of providers on referrals and authorizations and Nonavailability Statements (NASs), as appropriate.

4.10.1. Provider Identifier Association Requirements

All NPIs shall be associated with legacy provider numbers and subidentifiers in the contractors' provider file, as appropriate. TMA is not requiring contractors to associate NPIs with legacy provider numbers on the TMA provider file.

4.10.1.1. *Each legacy provider number for an individual provider, who meets the HHS definition of a "covered entity", shall be associated with a Type 1, individual NPI. See Figure 21-4-1.*

FIGURE 21-4-1 PROFESSIONAL (INDIVIDUAL/TYPE 1) PROVIDER

PROVIDER NAME	LEGACY PROVIDER NUMBER	LEGACY SUB ID	OFFICE ADDRESS(ES) (SERVICE LOCATION)	INDIVIDUAL NPI
Dr. Jones	123456789	0001	212 Main Street	7654321012
Dr. Jones	123456789	0002	313 Oak Street	7654321012
Dr. Jones	123456789	0003	414 Maple Street	7654321012

For claims processing purposes, the contractor's system shall be able to identify the place where care was rendered utilizing the "Service Location" field in the 837 and associate it with the individual provider's legacy provider identifier and subidentifier, as appropriate, to determine the appropriate reimbursement rate. The billing provider's name and address may or may not be different from "Service Location".

4.10.1.2. *Each legacy provider number and sub-identifier record for a clinic or group practice shall be associated with a Type 2, organizational NPI, as appropriate. For each legacy group practice provider and sub-identifier, where the sub-identifier represents a subpart that has been separately enumerated (e.g., different location or specialty, etc.) by the organizational entity, the contractor shall associate the Type 2 NPI for each subpart provider record in the provider file. See Figure 21-4-2.*

FIGURE 21-4-2 GROUP PRACTICE/CLINIC (ORGANIZATIONAL/TYPE 2) PROVIDER

PROVIDER NAME	LEGACY PROVIDER NUMBER	LEGACY SUB ID	ORGANIZATIONAL NPI (TYPE 2)
City Wide Clinic	765432193	A001	2101213456

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 21, SECTION 4

HEALTH AND HUMAN SERVICES (HHS) STANDARD UNIQUE HEALTH IDENTIFIER FOR
HEALTH CARE PROVIDERS FINAL RULE

For each legacy group practice provider and sub-identifier where the sub-identifier represents a different individual provider, the contractor shall associate the legacy group practice provider number with the Type 2 NPI for the group practice, as appropriate. See Figure 21-4-3.

FIGURE 21-4-3 GROUP PRACTICE/CLINIC WITH MULTIPLE INDIVIDUAL PROVIDERS

PROVIDER NAME	LEGACY PROVIDER NUMBER	LEGACY SUB ID	ORGANIZATIONAL NPI (TYPE 2)	PROVIDER NAME	INDIVIDUAL NPI (TYPE 1)
City Wide Clinic	765432193	A002	2101213456	Dr. Jones	3456289654
City Wide Clinic	765432193	A003	2101213456	Dr. Smith	1769335417
City Wide Clinic	765432193	A004	2101213456	Dr. Allen	2869551769

4.10.1.3. Institutional Providers

4.10.1.3.1. *Each legacy provider number and sub-identifier record for an institutional provider shall be associated with a Type 2, organizational NPI, as appropriate. For each legacy institutional provider and sub-identifier, where the sub-identifier represents a subpart that has been separately enumerated (e.g., different department or unit, etc.) by the organizational entity, the contractor shall associate the Type 2 NPI for each subpart provider record in the provider file, as appropriate. See Figure 21-4-4.*

FIGURE 21-4-4 INSTITUTIONAL PROVIDER WITH SUBPARTS ENUMERATED

LEGACY PROVIDER NUMBER	LEGACY SUB ID	PROVIDER/DEPARTMENT	ORGANIZATIONAL NPI (TYPE 2)
321456789	0000	St. Mary's Hospital	4563214897
321456789	0001	Radiology	7218954673
321456789	002	Neurology	2184696732
321456789	003	Obstetrics	8759648234

4.10.1.3.2. *For each legacy institutional provider and sub-identifier, where the institutional provider has chosen to only enumerate the "Primary" or "Overarching" organization, and not its separate departments or subparts, the contractor shall associate the Type 2, organizational NPI for the "Primary" organizational provider with each legacy sub-identifier associated with the "Primary" organizational NPI, as appropriate. For example, Mercy Medical Center is the "Primary" organizational provider and has three different departments; Mercy Medical Center has a legacy provider number and each department has a legacy provider number. Mercy Medical Center obtains an NPI, but decides not to separately identify those three departments, the legacy identifier for each department must be associated with the NPI for Mercy Medical Center. See Figure 21-4-5.*

FIGURE 21-4-5 INSTITUTIONAL PROVIDER WITHOUT SUBPARTS ENUMERATED

LEGACY PROVIDER NUMBER	LEGACY SUB ID	PROVIDER/DEPARTMENT	ORGANIZATIONAL NPI (TYPE 2)
332158989	0000	Mercy Medical Center	7896541223
332158989	0001	Radiology	7896541223
332158989	0002	Neurology	7896541223
332158989	0003	Obstetrics	7896541223

4.11. NPI Usage In Standard Transactions

The NPI will be collected and retained for use in claim activities, to include the processing and resolution of claims, duplicate claims identification, medical utilization, fraud investigation, third party claim submissions and claim reporting. Until all affected purchased care systems use only the NPI, the NPI and legacy identifiers will be supported.

- *ASC X12N 837 - Health Care Claim: Professional and Institutional - The NPI will be submitted in accordance with the usage specifications of the HIPAA Implementation Guide, its addendas and any companion documents.*
- *ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry and Response - The NPI will be submitted in accordance with the usage specifications of the HIPAA Implementation Guide, its addendas and any companion documents. DEERS will capture and maintain the NPI for individual providers to facilitate Health Care Eligibility Inquiry and Response transactions and has the capability to capture and maintain the NPI for organizational providers.*
- *Accredited Standards Committee (ASC) X12N 278 - Health Care Services Review - Request for Review and Response - The NPI will be submitted in accordance with the usage specifications of the HIPAA Implementation Guide, its addendas and any companion documents.*
- *ASC X12N 276/277 - Health Care Claims Status Request and Response - The NPI will be submitted in accordance with the usage specifications of the HIPAA Implementation Guide, its addenda and any companion documents. When required, the NPI shall be used in the electronic standard exchange between entities requesting health care claim status, organizations sending the health care claim status response and other business partners affiliated with the health care claim status request and response.*
- *ASC X12N 834 - Benefit Enrollment and Maintenance - DMDC will modify DOES to include the NPI where appropriate and in compliance with the HIPAA Implementation Guide, its addenda and any specifications.*
- *ASC X12N 835 - Health Care Claim Payment/Advice - The NPI will be submitted in accordance with the usage specifications of the HIPAA Implementation Guide, its addenda and any companion documents. The NPI will be used when communicating the status of a health care claim payment. Contractors must be able to use NPI and any other pertinent identifiers to correctly credit and debit the provider.*
- *National Council for Prescription Drug Program (NCPDP) Version 5, Release 1 - This NCPDP transaction may be used for eligibility checking as well as for claims-related transmissions. Contractors must be able to utilize the NPI in the transaction as defined in NCPDP guidance for the implementation and use of the transaction. For retail pharmacy, the following implementation specifications are named as standards: The Telecommunications Implementation Guide, Version 5, Release 1, dated September 1999, NCPDPs, as referenced in §§162.1102, 162.1202, 162.1602, and 162.1802 of the Rule and*

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 21, SECTION 4

HEALTH AND HUMAN SERVICES (HHS) STANDARD UNIQUE HEALTH IDENTIFIER FOR
HEALTH CARE PROVIDERS FINAL RULE

the equivalent Batch Standard Batch Implementation Guide, Version 1 Release 1, January 2000, NCPDPs as referenced in §§162.1102, 162.1202, 162.1302, and 162.1802 of the rule.

- *Companion Guides - Contractors will modify Companion Guides to provide specific guidance with regard to the NPI and its corresponding entity type code for use as the primary provider identifier, as appropriate.*

4.12. Web Server Technology

Contractors may choose to utilize the NPI for other provider identification purposes, at no cost to the Government and at their own discretion, on contractor developed and maintained web applications. However, this is not to be construed as instruction from TMA to develop, operate, modify, or maintain contractor web applications. Use of the NPI on contractor web applications must be in accordance with the requirements of the Final Rule.

5.0. TESTING

For all HIPAA-compliant electronic standard transactions that require the NPI to be used as the primary identifier for the provider, contractors shall ensure their capability to accept and adjudicate such transactions. Contractors shall test all processes that have been modified and/or implemented to maintain, send and receive NPI data, to include standard transactions, at least 120 days prior to implementation or upon direction of the CO. Contractors shall provide written certification to the CO of the successful testing of the receipt and processing of all HIPAA-compliant electronic standard transactions in accordance with the current Implementation Guide for the transaction, no later than the implementation date of the Final Rule or as directed by the CO.

34. INDIRECT TREATMENT RELATIONSHIP: The Privacy Regulation defines “Indirect Treatment Relationship” as “a relationship between an individual and a health care provider in which:

- (1) The health care provider delivers health care to the individual based on the orders of another health care provider; and
- (2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.”

35. INDIVIDUAL: The Privacy Regulation defines the “Individual” as being “the person who is the subject of protected health information.”

36. INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION: The Privacy Regulation defines “Individually Identifiable Health Information” as “information that is a subset of health information, including demographic information collected from an individual, and:

- (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - (i) That identifies the individual; or
 - (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.”

37. LAW ENFORCEMENT OFFICIAL: The Privacy Regulation defines “Law Enforcement Official” as “an officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

- (1) Investigate or conduct an official inquiry into a potential violation of law; or
- (2) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

38. LEGACY IDENTIFIER: *Any provider identifier besides the NPI and Federal Tax IDs. Legacy identifiers may include but not be limited to OSCAR, NSC, PINS, UPINS and other identifiers. A Federal Tax ID is not considered a legacy identifier for health care purposes as it's primary purpose is to support IRS 1099 reporting.*

39. LIMITED DATA SET: A limited data set is protected health information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

- (1) Names;

- (2) Postal address information, other than town or city, State, and zip code;
- (3) Telephone numbers;
- (4) Fax numbers;
- (5) Electronic mail addresses;
- (6) Social security numbers;
- (7) Medical record numbers;
- (8) Health plan beneficiary numbers;
- (9) Account numbers;
- (10) Certificate/license numbers
- (11) Vehicle identifiers and serial numbers, including license plate numbers;
- (12) Device identifiers and serial numbers;
- (13) Web Universal Resource Locators (URLs);
- (14) Internet Protocol (IP) address numbers;
- (15) Biometric identifiers, including finger and voice prints; and
- (16) Full face photographic images and any comparable images.

40. MAINTAIN OR MAINTENANCE: The Transaction and Code Sets Regulation defines “Maintain Or Maintenance” as referring, “to activities necessary to support the use of a standard adopted by the Secretary (HHS), including technical corrections to an implementation specification, and enhancements, or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or modification to an adopted standard or implementation specification.”

41. MARKETING: The Privacy Regulation defines “Marketing” as “to make a communication about a product or service to encourage recipients of the communication to purchase or use the product or service. Marketing excludes a communication made to an individual:

- (1) To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits;
- (2) For the treatment of that individual; or

(3) For case management or care coordination for that individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to that individual."

(4) The DoD Health Information Privacy Regulation adds the following: "To inform an individual who is a member of a uniformed service or a covered beneficiary of the Military Health System of benefits, services, coverages, limitations, costs, procedures, rights, obligations, options, and other information concerning the Military Health System as established by law and applicable regulations;"

42. MAXIMUM DEFINED DATA SET: The Transaction and Code Sets Regulation defines "Maximum Defined Data Set" as "all of the required data elements for a particular standard based on a specific implementation specification."

43. NATIONAL PROVIDER IDENTIFIER (NPI): *The HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers; Final Rule (45 CFR 162), defines "National Provider Identifier" as a standard unique health identifier for health care providers. The NPI format consists of an all numeric identifier, 10 positions in length, with an International Standard Organization (ISO) standard check-digit in the 10th position (§162.406(a)). The NPI will not contain intelligence about the health care provider.*

44. ORGANIZED HEALTH CARE ARRANGEMENT: The DoD Health Information Privacy Regulation indicates that "the MHS is an organized health care arrangement". The Privacy Regulation defines "Organized Health Care Arrangement" as follows:

"(1) A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

(2) An organized system of health care in which more than one covered entity participates, and in which the participating covered entities:

(i) Hold themselves out to the public as participating in a joint arrangement; and

(ii) Participate in joint activities that include at least one of the following:

(A) Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;

(B) Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or

(C) Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

- (3) A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to protected health information created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;
- (4) A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or
- (5) The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to protected health information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans."

45. PAYMENT: The Privacy Regulation defines "Payment" as the following:

- (1) The activities undertaken by:
 - (i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or
 - (ii) A covered health care provider or health plan to obtain or provide reimbursement for the provision of health care; and
- (2) The activities in paragraph (1) of the definition relate to the individual to whom health care is provided and include, but are not limited to:
 - (i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
 - (ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 - (iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
 - (iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
 - (v) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
 - (vi) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:
 - (A) Name and address;

- (B) Date of birth;
- (C) Social Security number;
- (D) Payment history;
- (E) Account number; and
- (F) Name and address of the health care provider and/or health plan.

46. PROTECTED HEALTH INFORMATION: The Privacy Regulation defines “Protected Health Information” as individually identifiable health information:

- (1) Except as provided in paragraph (2) of this definition, that is:
 - (i) Transmitted by electronic media;
 - (ii) Maintained in any medium described in the definition of electronic media at §162.103 of this subchapter; or
 - (iii) Transmitted or maintained in any other form or medium.
- (2) Protected health information excludes individually identifiable health information in:
 - (i) Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g;
 - (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
 - (iii) Employment records held by a covered entity in its role as an employer.”

47. PSYCHOTHERAPY NOTES: The Privacy Regulation defines “Psychotherapy Notes” as “notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.”

48. PUBLIC HEALTH AUTHORITY: The Privacy Regulation defines “Public Health Authority” as “an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.” The DoD Health Information Privacy Regulation adds “The term “public health authority” includes any DoD

Component authorized under applicable DoD regulation to carry out public health activities, including medical surveillance activities under DoD Directive 6490.2 (reference (g)).

49. REQUIRED BY LAW: The Privacy Regulation defines “Required By Law” to mean “a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.” The DoD Health Information Privacy Regulation specifies the following: “Required by law includes any mandate contained in a DoD Regulation that requires a covered entity (or other person functioning under the authority of a covered entity) to make a use or disclosure and is enforceable in a court of law. The attribute of being enforceable in a court of law means that in a court or court-martial proceeding, a person required by the mandate to comply would be held to have a legal duty to comply or, in the case of noncompliance, to have had a legal duty to have complied. Required by law also includes any DoD regulation requiring the production of information necessary to establish eligibility for reimbursement or coverage under TRICARE/CHAMPUS.

50. RESEARCH: The DoD Health Information Privacy Regulation provides the following definition: “A systematic investigation, including research, development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.”

51. SECRETARY OF HEALTH AND HUMAN SERVICES: The DoD Health Information Privacy Regulation provides the following definition: “The Secretary of Health and Human Services or any other officer or employee of HHS to whom the relevant authority has been delegated.

52. SEGMENT: The Transaction and Code Sets Regulation defines “Segment” as “a group of related data elements in a transaction.”

53. STANDARD TRANSACTION: The Transaction and Code Sets Regulation defines “Standard Transaction” as “a transaction that complies with the applicable standard adopted under this part.”

54. STATE: The DoD Health Information Privacy Regulation defines “State” as “One of the following:

For a health plan established or regulated by Federal law, State has the meaning set forth in the applicable section of the United States Code for such health plan.

For all other purposes, State means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.”

55. SUMMARY HEALTH INFORMATION: The Privacy Regulation defines “Summary Health Information” as “information, that may be individually identifiable health information, and:

- (1) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
- (2) From which the information described at §164.514(b)(2)(i) has been deleted, except that the geographic information described in §164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code."

56. TRADING PARTNER AGREEMENT: The Transaction and Code Sets Regulation and the Privacy Regulation define "Trading Partner Agreement" as follows:

"**Trading partner agreement** means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)"

57. TRANSACTION: The Transaction and Code Sets Regulation and the Privacy Regulation define "Transaction" as follows:

"**Transaction** means the transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

- (1) Health care claims or equivalent encounter information.
- (2) Health care payment and remittance advice.
- (3) Coordination of benefits.
- (4) Health care claims status.
- (5) Enrollment and disenrollment in a health plan.
- (6) Eligibility for a health plan.
- (7) Health plan premium payments.
- (8) Referral certification and authorization.
- (9) First report of injury.
- (10) Health claims attachments.
- (11) Other transactions that the Secretary may prescribe by regulation.

58. TREATMENT: The Privacy Regulation defines "Treatment" as the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a

third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

59. USE: The Privacy Regulation defines "Use" as "with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information."

60. WORKFORCE: The Privacy Regulation defines, "Workforce" as "employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity is under the direct control of such entity, whether or not they are paid by the covered entity."