Chapter 19 Section 2

Standards For Electronic Transactions Final Rule

1.0 BACKGROUND AND PROVISIONS

The Department of Health and Human Services (DHHS) published the first administrative simplification related final rule on August 17, 2000, which added subchapter C, "Administrative Data Standards and Related Requirements," to 45 CFR subtitle A. Subchapter C includes Parts 160 and 162, which will be referred to here as the "Standards for Electronic Transactions Final Rule" or "Final Rule," or the "Transaction and Code Sets Rule," or "Rule." On February 20, 2003, HHS published a Final Rule which adopted modifications to implementation specifications for health care entities and others, and modifications to implementation specifications for several electronic transaction standards. This Final Rule, known as "Health Insurance Reform: Modifications to Electronic Data Transaction Standards and Code Sets", makes modification to 45 CFR Part 162.

1.1 Compliance Date

Compliance with the electronic standards for Transactions and Code Sets Final Rule is required No Later Than (NLT) October 16, 2003.

1.2 Applicability

The Transaction and Code Sets Rule applies to health plans, health care clearinghouses, and health care providers who transmit any health information in electronic form in connection with a transaction covered by the rule. The Rule refers to health plans, health care clearinghouses, and health care providers as "covered entities." The Rule specifically names the health care program for active duty military personnel under Title 10 of the United States Code (USC) and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined in 10 USC 1072(4), as health plans.

1.3 Transaction Implementation Specification Standards

1.3.1 The Rule names the following transaction implementation specifications as standards.

- The ASC X12N 837 - Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097, and Addenda to Health Care Claim: Dental Version 4010, October 2002, Washington Publishing Company, 004010X097A1, as referenced in §162.1102 and §162.1802 of the Rule.

- The ASC X12N 837 - Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098, and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1, as referenced in §162.1102 and §162.1802 of the Rule.

- The ASC X12N 837 - Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096, and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1, as referenced in §162.1102 and §162.1802 of the Rule.

- The ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092, and Addenda to Health Care Eligibility Benefit Inquiry and Response. Version 4010, October 2002, Washington Publishing Company, 004010X092A1, as referenced in §162.1202 of the Rule.

- The ASC X12N 278 - Health Care Services Review - Request for Review and Response, Version 4010, May 2000, Washington Publishing Company, 004010X094, and Addenda to Health Care Services Review - Request for Review and Response, Version 4010, October 2002, Washington Publishing Company, 004010X094A1, as referenced in §162.1302 of the Rule.

- The ASC X12N 276/277 - Health Care Claim Status Request and Response, Version 4010, May 2000, Washington Publishing Company, 004010X093, and Addenda to Health Care Claim Status Request and Response, Version 4010, October 2002, Washington Publishing Company, 004010X093A1, as referenced in §162.1402 of the Rule.

- The ASC X12N 834 - Benefit Enrollment and Maintenance, Version 4010, May 2000, Washington Publishing Company, 004010X095, and Addenda to Benefit Enrollment and Maintenance, Version 4010, October 2002, Washington Publishing Company, 004010X095A1, as referenced in §162.1502 of the Rule.

- The ASC X12N 835 - Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1, as referenced in §162.1602 of the Rule.

- The ASC X12N 820 - Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, May 2000, Washington Publishing Company, 004010X061, and Addenda to Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, October 2002, Washington Publishing Company, 004010X061A1, as referenced in §162.1702 of the Rule.

1.3.2 For retail pharmacy the following implementation specifications are named as standards:

- The Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, National Council for Prescription Drug Programs, as referenced in §§162.1102, 162.1202, 162.1602, and 162.1802 of the Rule and the equivalent Batch Standard Batch Implementation Guide, Version 1 Release 1, January 2000, National Council for Prescription Drug Programs, as referenced in §§162.1102, 162.1202, 162.1302, and 162.1802 of the Rule.

1.4 Code Set General Requirements

The Rule stipulates that when conducting a transaction, a covered entity must:

1.4.1 Use the applicable medical data code sets described in §162.1002 as specified in the adopted implementation specifications that are valid at the time the health care is furnished.

1.4.2 Use the nonmedical data code sets as specified in the adopted implementation specifications that are valid at the time the transaction is initiated.

1.5 Medical Code Set Standards

The Secretary, HHS, adopted the following as the standard medical data code sets.

1.5.1 International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions:

- Diseases.
- Injuries.
- Impairments.
- Other health problems and their manifestations.
- Causes of injury, disease, impairment, or other health problems.

1.5.2 ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients by hospitals:

- Prevention.
- Diagnosis.
- Treatment.
- Management.

1.5.3 For retail pharmacy transactions only, National Drug Codes (NDC), as maintained and distributed by HHS, in collaboration with drug manufacturers, for reporting the following in retail pharmacy transactions for which standards have been adopted:

- Drugs.
- Biologics.

Note: For transactions involving institutional and professional providers (non-retail pharmacy transactions), Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) codes, may be used (e.g., HCPCS J-codes). See paragraph 1.5.6.

1.5.4 Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services. The Current Dental Terminology (CDT) Manual contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

1.5.5 The combination of HCPCS, as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. These services include, but are not limited to, the following:

- Physician services.
- Physical and occupational therapy services.
- Radiologic procedures.
- Clinical laboratory tests.
- Other medical diagnostic procedures.
- Hearing and vision services.
- Transportation services including ambulance.

1.5.6 The HCPCS, as maintained and distributed by HHS, for all other substances, equipment, supplies, or other items used in health care services except drugs and biologics. These items include, but are not limited to, the following:

- Medical supplies.
- Orthotic and prosthetic devices.
- Durable medical equipment.

Note: The Rule does not name HCPCS Level III, local codes, as a standard medical data code set. HCPCS Level III local codes shall not be used in standard transactions after compliance with the Rule is required.

1.6 General Requirements For Covered Entities

The Rule requires the following of all covered entities.

1.6.1 "General rule. Except as otherwise provided in this part, if a covered entity conducts with another covered entity (or within the same covered entity), using electronic media, a transaction for which the Secretary (HHS) has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction."

1.6.2 "Exception for direct data entry transactions. A health care provider electing to use direct data entry offered by a health plan to conduct a transaction for which a standard has been adopted under this part must use the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirement of the standard."

1.6.3 "Use of a business associate. A covered entity may use a business associate, including a health care clearinghouse, to conduct a transaction covered by this part. If a covered entity chooses to use a business associate to conduct all or part of a transaction on behalf of the covered entity, the covered entity must require the business associate to do the following:

- Comply with all applicable requirements of this part; (

- Require any agent or subcontractor to comply with all applicable requirements of this part." See Appendix B for the definition of "business associate."

1.7 General Requirements For Health Plans

1.7.1 The Rule adds the following requirements to health plans as general rules.

- "If an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so."
- "A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction."
- "A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan (for example, coordination of benefits information)."
- "A health plan may not offer an incentive for a health care provider to conduct a transaction covered by this part as a transaction described under the exception provided for in §162.923(b)." (Exception for direct data entry transactions.)
- "A health plan that operates as a health care clearinghouse, or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health plan."

1.7.2 The Rule adds the following requirements to health plans regarding coordination of benefits.

- "If a health plan receives a standard transaction and coordinates benefits with another health plan (or another payer), it must store the coordination of benefits data it needs to forward the standard transaction to the other health plan (or other payer)."

1.7.3 The Rule adds the following requirements to health plans regarding Code Sets.

1.7.4 A health plan must meet each of the following requirements:

- Accept and promptly process any standard transaction that contains codes that are valid, as provided in subpart J of this part. (Code Sets)
- Keep code sets for the current billing period and appeals periods still open to processing under the terms of the health plan's coverage.

2.0 TRICARE OBJECTIVES

2.1 The TRICARE program shall be in full compliance with the Transaction and Code Sets Rule.

2.2 MCSC systems shall be able to receive, process, and send compliant standard transactions where required.

3.0 CONTRACTOR RELATIONSHIPS TO THE TRICARE HEALTH PLAN

3.1 The Transaction and Code Sets Rule specifically names the health care program for active duty military personnel under Title 10 of the USC and the CHAMPUS as defined in 10 USC 1072(4), as health plans. For the purposes of implementing the Transaction and Code Sets Rule, the term "TRICARE" will be used in this chapter to mean a combination of both the Direct Care (DC) and purchased care systems. TRICARE is therefore a health plan.

3.2 The relationships of the entities that comprise TRICARE determine, in part, where standard transactions must be used. Determinations as to when and where the transaction standards apply are not based on whether a transaction occurs within or outside of a "corporate entity" but rather are based on the answers to the two following questions. (1) Is the transaction initiated by a covered entity or its business associate? If the answer is "yes," then the standard applies and question (2) must be answered. If "no," then the standard does not apply and need not be used. (2) Is the transaction one for which the Secretary has adopted a standard? If "yes," the standard must be used. If "no," the standard need not be used. To decide if a transaction is one for which a standard has been adopted, the definition of the transaction, as provided in the rule, must be used. It is also critical to know who is a business associate of the TRICARE health plan and who is not in determining where standard transactions must be used within TRICARE. See Appendix B for the definition of "business associate."

3.3 The following table defines the TRICARE entities and their relationships to the TRICARE health plan.

ENTITY	COVERED ENTITIES			NON-COVERED ENTITY	BUSINESS ASSOCIATE OF THE TRICARE HEALTH PLAN?
	HEALTH PLAN?	PROVIDER?	CLEARING-HOUSE?	EMPLOYER?	
Department of Defense (DoD) (Army, Navy, Air Force, Marines, Coast Guard)	N	N	N	Y	N
TRICARE Health Plan (Represents both the Health Care Program for Active Duty Military Personnel under Title 10 of the USC and the CHAMPUS as defined in 10 USC 1072(4).)	Y	N	N	N	N
Military Treatment Facilities (MTFs) (Supporting Systems: Composite Health Care System (CHCS), Armed Forces Health Longitudinal Technology Application (AHLTA), Third Party Outpatient Collections System (TPOCS), and others)	N	Y	N	N	N
Defense Manpower Data Center (DMDC) (DEERS)	N	N	N	N	Y
MCSCs	N	N	N	N	Y
TRICARE Dual Eligible FI Contract (TDEFIC)	N	N	N	N	Y
Defense Finance and Accounting Service (DFAS)	N	N	N	Y	N
TRICARE Dental Program (TDP) Contractor	Y	N	N	N	Y (for foreign claims processing only)
Active Duty Dental Program Contractor	Y	N	N	N	N

ENTITY	COVERED ENTITIES			NON-COVERED ENTITY	BUSINESS ASSOCIATE OF THE TRICARE HEALTH PLAN?
	HEALTH PLAN?	PROVIDER?	CLEARING-HOUSE?	EMPLOYER?	
TRICARE Retiree Dental Program (TRDP) Contractor	Y	N	N	N	N
Pharmacy Data Transaction System (PDTS) Contractor	N	N	N	N	Y
Designated Provider (DP) Contractors	Y	Y	N	N	N
Military Medical Support Office (MMSO)	N	N	N	N	Y
DoD Senior Pharmacy Inquiry Line Contractor	N	N	N	N	Y
Continued Health Care Benefit Program (CHCBP) Contractor	N	N	N	N	Y
TRICARE Quality Monitoring Contractor (TQMC)	N	N	N	N	Y
Contractor for Data Analysis for the DP Contracts	N	N	N	N	Y
TRICARE Global Remote Overseas (TGRO) Health Care Contractor	N	N	N	N	Y
TMA (Supporting Systems: DEERS Catastrophic Cap and Deductible (CCDD), payment record databases (TRICARE Encounter Data (TED) records, TED Provider (TEPRV) records, and TED Pricing (TEPRC) records), management databases (MHS Data Repository and its associated data marts)	N	N	N	N	Y
TRICARE Mail Order Pharmacy (TMOP)	N	Y	N	N	N
TRICARE Retail Pharmacy Benefits (TRPB) Contractor	N	N	N	N	Y
TRICARE Regional Offices (TROs)	N	N	N	N	Y

4.0 TRANSACTION REQUIREMENTS FOR TRICARE CONTRACTORS

4.1 General

4.1.1 Transactions shall be implemented in accordance with the transaction implementation specifications and any addenda, named by the Secretary, HHS, as standards (see paragraph 1.3).

4.1.2 Standard transactions received by contractors from trading partners that are correct at the interchange control structure level (envelope) and that are syntactically correct at the standard level and at the implementation guide level and are semantically correct at the implementation guide level must be accepted. Front-end business or application level edits for transaction content, such as an edit for a recognized provider number, shall not be the cause of rejecting an otherwise syntactically correct transaction. Front-end business or application level edits shall be applied after the transaction has been accepted. Claims failing front-end business or application edits, after passing syntax and semantic edits, shall be rejected, developed or denied in accordance with established procedures for such actions.

4.2 Transactions Exchanged Between Contractors And Providers (Network And Non-Network Providers, MTFs (CHCS))

4.2.1 Transactions exchanged between contractors and providers must be in standard format.

4.2.2 The contractors must be able to receive, process, and send the following transactions from and to providers:

4.2.2.1 Claims Transactions

[Receive 837 Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Institutional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Dental, Version 4010.

4.2.2.2 Coordination Of Benefits Transactions

[Receive 837 Coordination of Benefits Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Institutional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Dental, Version 4010.

4.2.2.3 Eligibility Inquiry And Response Transactions

[Receive 270 Transactions and Send 271 Transactions]

- The ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry and Response, Version 4010.

4.2.2.4 Referral Certification And Authorization Transactions

[Receive 278 Requests and Send 278 Responses]

- The ASC X12N 278 - Health Care Services Review - Request for Review and Response, Version 4010.

4.2.2.5 Claim Status Request And Response Transactions

[Receive 276 Transactions and Send 277 Transactions]

- The ASC X12N 276/277 - Health Care Claim Status Request and Response, Version 4010.

4.2.2.6 Payment And Remittance Advice Transactions

[Send 835 Transactions]

- The ASC X12N 835 - Health Care Claim Payment/Advice, Version 4010.

4.3 Transactions Exchanged Between Contractors And Other Health Plans (And Employers, Where Applicable)

4.3.1 Transactions exchanged between contractors and other health plans (including TRICARE supplemental plans) must be in standard format.

4.3.2 The contractors must be able to receive, process, and send the following transactions from and to other health plans:

4.3.2.1 Coordination Of Benefits Transactions:

[Send and Receive all 837 Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Institutional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Dental, Version 4010.

4.3.2.2 Eligibility Inquiry And Response Transactions:

[Send and Receive 270 Transactions; Send and Receive 271 Transactions]

- The ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry and Response, Version 4010.

4.3.2.3 Referral Certification And Authorization Transactions

[Send and Receive 278 Requests; Send and Receive 278 Responses]

- The ASC X12N 278 - Health Care Services Review - Request for Review and Response, Version 4010.

4.3.2.4 Payment And Remittance Advice Transactions:

[Send 835 Transactions]

- The ASC X12N 835 - Health Care Claim Payment/Advice, Version 4010.

4.3.2.5 Claim Status Request And Response Transactions:

[Receive 276 Transactions and Send 277 Transactions]

- The ASC X12N 276/277 - Health Care Claim Status Request and Response, Version 4010.

4.3.2.6 Health Plan Premium Payment Transactions:

[Receive 820 Transactions]

- The ASC X12N820 - Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010.

4.4 Transactions Exchanged Between Contractors And DMDC (DEERS)

4.4.1 Eligibility Inquiries And Response Transactions

Based on the "two-question rule" for determining when a transaction must be in standard format (see paragraph 3.2), and the definition of the Eligibility for a Health Plan Transaction in the Rule, eligibility inquiry and response transactions occurring between business associates of the same health plan need not be in standard format. Only when the inquiries and responses are between providers and health plans or between health plans and health plans must these transactions be in standard format. Because the contractors and DMDC (DEERS) are business associates of the same health plan, eligibility inquiry and response transactions between them may be performed in non-standard format.

4.4.1.1 Real-time eligibility inquiries and responses, associated with enrollment processing, between the contractors and DMDC (DEERS) shall be performed using the DEERS Online Enrollment System (DOES).

4.4.1.2 Real-time and batch eligibility inquiries and responses between the contractors and DMDC (DEERS) for claims processing and other administrative purposes will be in DEERS specified format.

4.4.2 Enrollment And Disenrollment Transactions

TRICARE Prime enrollment and disenrollment transactions between the contractors and DMDC (DEERS) may be performed using the DEERS Online Enrollment System (DOES). The Government will provide a HIPAA standard data and condition compliant version of DOES for contractor use. Note: Transactions generated by DMDC (DEERS) that validate that enrollments have been established and that are used by contractors to update their system files, are not considered covered transactions and may be sent in proprietary format.

4.5 Transactions Exchanged Between Contractors And Providers (Network And Non-Network Providers, MTFs (CHCS)) Through Direct Data Entry Systems

4.5.1 Direct Data Entry Systems

4.5.1.1 All transactions covered under the Transaction and Code Sets Rule occurring between contractors and network and non-network providers and MTFs must be in standard format, unless subject to the exception in paragraph 1.6.2. Contractors may offer a direct data entry system for use by providers, however, a direct data entry system does not replace the requirement to support the standard transactions. Direct data entry systems must be compliant with standard transaction data content and conditions.

4.5.1.2 A direct data entry system may not add to or delete from the standard data elements and code values. Direct data entry systems may take the form of web applications. Non-standard data elements and code values may be included in the direct data entry system if the non-standard data is obtained or sent through a separate mechanism such as a web page that is separate from the web page containing the standard data content, and the resolution of the standard transaction does not depend on the additional information.

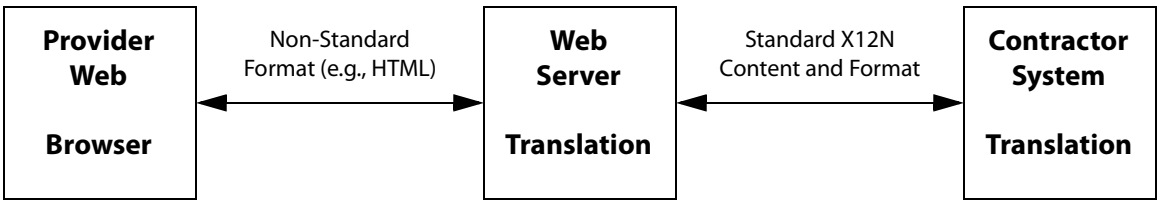
4.5.2 Web Server Technology

Note: This section discusses web server technology and, as a courtesy, provides guidance as to HIPAA requirements for the use of web applications. It is not an instruction from TMA to develop, operate, modify, or maintain contractor web applications. This section provides the HIPAA rules for operating web applications within the context of the Transaction and Code Sets Rule and provides TMA compliance expectations for any applicable web application that has been deployed by an contractor. Development, operation, modification and maintenance costs of contractor web applications are at contractor expense.

4.5.2.1 Web server technology may be used. The browser provides a template for use in uploading and downloading data. The browser data structure will be non-standard HyperText Markup Language (HTML). Data content in the HTML transmission must meet the X12N standard or conversion to the standard is required. The provider's web server application can perform the translation and transmit a compliant transaction. The contractor will need to translate (convert) the compliant transaction to the contractor's system format (if it is a non-standard format). Translation of data content depends on whether the contractor accepts and uses standard data, or accepts and translates to non-standard data.[1]

4.5.2.2 Browser-To-Web Server Data Exchange (not part of the receiver's system):

When data is being entered onto a server that is not part of the receiver's system and is being repackaged for transmission to the receiver's system, the transaction between the server and the receiver's system must be in Standard X12 format.



[1] This information was drawn from the HCFA paper, **The Role of Translators: Do We Need Them? What Can They Do for Us? What Are the Installation Alternatives? How Do We Choose the Right Ones?** Note: The HCFA is now doing business as the Centers for Medicare and Medicaid Services (CMS).

4.5.2.3 Browser-To-Web Server Data Exchange (part of the receiver's system)

If a server is using a browser to directly enter data onto a server that is part of the receiver's system, such a transaction is considered a direct data entry transaction that need only meet the standard data content and condition requirements.

4.6 Transactions Involving Foreign Entities

4.6.1 Electronic transactions from overseas MTFs and from U.S. Territories will be sent directly to the contractor in standard format or routed through a U.S. based clearinghouse for translation into standard format prior to being sent to the contractor.

4.6.2 Electronic transactions submitted by foreign entities, such as claims transactions from foreign providers, may be accepted directly by the contractor or they may be routed through a clearinghouse to the contractor for processing. Transactions submitted by foreign entities, except for those originating from U.S. Territories or overseas MTFs, are not covered transactions and may be accepted by the contractor in non-standard format.

4.6.2.1 Except for transactions originating from U.S. territories or overseas MTFs (which must be in standard format), the contractor may define the format or formats they will accept from foreign entities, either directly or through a clearinghouse.

4.6.2.2 Where the TRICARE Global Remote Overseas (TGRO) health care contractor pays foreign claims and subsequently bills the contractor for reimbursement, claim data submitted to the contractor in support of the invoice shall be sent in standard format.

4.7 Transactions Exchanged Between Contractors And TMA

Payment Record Submissions, TED records, TEPRV records, and TEPRC records - Payment records are considered reports and are not covered transactions. Payment records shall be submitted in accordance with contract requirements.

4.8 Clearinghouse Use By Contractors

4.8.1 Contractors may use contracted clearinghouses for the purposes of receiving, translating, and routing electronic transactions on their behalf. Contractor-contracted clearinghouses may receive standard transactions, convert them into the contractors' system formats and route them to the contractors' systems for processing. Contractors may send non-standard formatted transactions to their contracted clearinghouses for the purposes of translating them into standard format and routing them to the intended recipients.

4.8.2 Transactions between health care clearinghouses must be conducted in standard format.

4.8.3 Where a contractor has contracted with the same clearinghouse as the entity that is submitting or receiving the transaction, the clearinghouse is required to convert the nonstandard transaction into the standard prior to converting it again to the intended recipient's format and sending it.

5.0 TRADING PARTNER AGREEMENTS

5.1 Contractors shall have trading partner agreements with all entities with which electronic transactions are exchanged. Where a provider uses a billing service or clearinghouse to exchange transactions, the contractor shall have a trading partner agreement with both the provider and billing service/clearinghouse. Trading partner agreements with providers shall contain a "provider signature on file" provision that will allow the contractor to process the electronic transaction if the provider signature on file requirement is not being met through another vehicle (e.g., provider certification). Contractors are required to develop and execute trading partner agreements that comply with all DoD and TMA privacy and security requirements (see paragraphs 3.0 and 4.0 for additional information regarding privacy and security). See Appendix B for the definition of "trading partner agreement." All trading partner agreements, including all existing and active trading partner agreements previously executed, shall be updated, and kept updated, to reflect current requirements.

5.2 Implementation Guide Requirements

5.2.1 Contractor trading partner agreements shall include, as recommended in the ANSI ASC X12N transaction implementation guides, any information regarding the processing, or adjudication of the transactions that will be helpful to the trading partners and that will simplify implementation.

5.2.2 Trading partner agreements shall **NOT**:

- Modify the definition, condition, or use of a data element or segment in a standard Implementation Guide.
- Add any additional data elements or segments to a standard Implementation Guide.
- Utilize any code or data values, which are not valid to a standard Implementation Guide.
- Change the meaning or intent of a standard Implementation Guide.

6.0 ADDITIONAL NON-HIPAA TRANSACTIONS REQUIRED

Contractors shall implement the following non-HIPAA mandated transactions as appropriate.

6.1 Acknowledgments

The following are required for a transaction to be HIPAA-compliant:

- The interchange or "envelope" must be correct;
- The transaction must be syntactically correct at the standard level;
- The transaction must be syntactically correct at the implementation guide level; and
- The transaction must be semantically correct at the implementation guide level.

Syntax relates to the structure of the data. Semantics relates to the meaning of the data. Any transaction that meets these four requirements is HIPAA compliant and must be accepted.

Note: In the case of a claim transaction, "accepted" does not mean that it must be paid. A transaction that is accepted may then be subjected to business or application level edits. "Accepted" transactions, i.e., those that are HIPAA compliant, that subsequently fail business or application level edits shall be rejected, developed, or denied in accordance with established procedures for such actions.

6.1.1 Interchange Acknowledgment

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Contractors shall develop and implement the capability to generate and send the following transaction.

- The ANSI ASC X12N TA1 - Interchange Acknowledgment, Version 4010.

6.1.2 Functional Acknowledgment

The functional 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.) Functional 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 4010 of the functional acknowledgment transaction does not report on implementation guide or business/application level edit errors. The functional 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 997 - Functional Acknowledgment, Version 4010.

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 Unsolicited Claim Status (277) [Health Care Information Status Notification Transaction Set (ANSI ASC X12N 277)] may be used to indicate which claims in an 837 batch were received electronically but not yet accepted into the adjudication system, which 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 Unsolicited Claim Status (277) [Health Care Information Status Notification Transaction Set - ANSI ASC X12N 277, Version 4010] in place of a proprietary acknowledgment.

6.2 Medicaid Subrogation Claims "Pay And Chase 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 (TRICARE Reimbursement Manual (TRM), Chapter 1, Section 21) 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 "pay and chase" claim from a Medicaid State Agency is not a HIPAA covered transaction since the Transaction and Code Sets Rule defines a health care claims 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. Also, Version 4010 of the ASC X12N 837 claims transactions does not support a billing from one health plan to another health plan.

- In accordance with existing TRICARE policy, contractors shall coordinate with the Medicaid State Agencies submitting 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.

7.0 MISCELLANEOUS REQUIREMENTS

7.1 Paper Transactions

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

7.1.2 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.

7.1.3 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 EOB to beneficiaries and providers, etc., apply to the processing of electronic transactions.

7.2 Attendance At Designated Standards Maintenance Organization (DSMO) Meetings And TMA Chief Information Officer (CIO) E-Health Meetings

7.2.1 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.

7.2.2 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.

7.2.3 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.

7.2.4 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 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.

7.2.5 Contractor representatives are responsible for keeping 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.

7.3 Provider Marketing

7.3.1 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.

7.3.2 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.

7.3.2.1 Data Retention And Audit Requirements

7.3.3 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.

7.3.4 Contractors shall be able to 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 also be able 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.

7.3.5 Transaction data is subject to audit by TMA, Regional Lead Agents, DoD, the DHHS, and other authorized government personnel. Contractors shall be able to retrieve and produce 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.

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