

STANDARDS FOR ELECTRONIC TRANSACTIONS FINAL RULE

1.0. BACKGROUND AND PROVISIONS

The Department of Health and Human Services (HHS) 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 Regulation," or "Regulation."

1.1. Compliance Date

Compliance with the Regulation is required no later than October 16, 2002. [Note: TMA applied to HHS to extend the compliance date to October 16, 2003.]

1.2. Applicability

The Transaction and Code Sets Regulation 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 Regulation refers to health plans, health care clearinghouses, and health care providers as "covered entities." The regulation specifically names the health care program for active duty military personnel under Title 10 of the United States Code and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined in 10 U.S.C. 1072(4), as health plans.

1.3. Transaction Implementation Specification Standards

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

- The ASC X12N 837 - Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097, as referenced in §§162.1102 and 162.1802 of the Regulation.
- The ASC X12N 837 - Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098, as referenced in §§162.1102 and 162.1802 of the Regulation.
- The ASC X12N 837 - Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096, as referenced in §§162.1102 and 162.1802 of the Regulation.

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- The ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092, as referenced in §162.1202 of the Regulation.
- The ASC X12N 278 - Health Care Services Review - Request for Review and Response, Version 4010, May 2000, Washington Publishing Company, 004010X094, as referenced in §162.1302 of the Regulation.
- The ASC X12N 276/277 - Health Care Claim Status Request and Response, Version 4010, May 2000, Washington Publishing Company, 004010X093, as referenced in §162.1402 of the Regulation.
- The ASC X12N 834 - Benefit Enrollment and Maintenance, Version 4010, May 2000, Washington Publishing Company, 004010X095, as referenced in §162.1502 of the Regulation.
- The ASC X12N 835 - Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, as referenced in §162.1602 of the Regulation.
- The ASC X12N 820 - Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, May 2000, Washington Publishing Company, 004010X061, as referenced in §162.1702 of the Regulation.

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 Regulation 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 Regulation.

1.4. Code Set General Requirements

The Regulation 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.

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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. International Classification of Diseases, 9th Edition, Clinical Modification, 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), 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 Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association, 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 Health Care Financing Administration Common Procedural Coding System (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 Regulation does not name The Health Care Financing Administration Common Procedural Coding System (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 Regulation is required.

1.6. General Requirements For Covered Entities

The Regulation 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: (1) Comply with all applicable requirements of this part; (2) Require any agent or subcontractor to comply with all applicable requirements of this part.” See [Chapter 21, Addendum A](#) for the definition of “business associate.”

1.7. General Requirements For Health Plans

1.7.1. The Regulation 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 Regulation 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 Regulation 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 Regulation.

2.2. Managed Care Support Contractor systems shall be able to receive, process, and send compliant standard transactions where required.

2.3. Managed Care Support Contractor systems shall be internally tested and independently certified that they are able to send and receive compliant transactions.

2.4. Managed Care Support Contractor systems shall be tested with their trading partners to verify that the systems are able to send and receive compliant transactions prior to exchanging transactions in a production environment.

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2.5. Managed Care Support Contractors shall create and test any data crosswalks and conversions necessary to ensure uninterrupted submission of contract compliant TRICARE Encounter Data Records (TEDs), TRICARE Encounter Provider Records (TEPRVs), and TRICARE Encounter Pricing Records (TEPRC) to TMA.

3.0. CONTRACTOR RELATIONSHIPS TO THE TRICARE HEALTH PLAN

3.1. The Transaction and Code Sets Regulation specifically names the health care program for active duty military personnel under Title 10 of the United States Code and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined in 10 U.S.C. 1072(4), as health plans. For the purposes of implementing the Transaction and Code Sets Regulation, the term “TRICARE” will be used in this chapter to mean a combination of both the direct care 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 regulation, 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 [Chapter 21, Addendum A](#) 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?	
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 United States Code and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined in 10 U.S.C. 1072(4).)	Y	N	N	N	N

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ENTITY	COVERED ENTITIES			NON-COVERED ENTITY	BUSINESS ASSOCIATE OF THE TRICARE HEALTH PLAN?
	HEALTH PLAN?	PROVIDER?	CLEARING-HOUSE?	EMPLOYER?	
MTFs (Supporting Systems: CHCS, CHCS II, TPOCS, UBO Consolidated System)	N	Y	N	N	N
DMDC (DEERS)	N	N	N	N	Y
Managed Care Support Contractors (MCSCs)	N	N	N	N	Y
<i>TRICARE Dual Eligible FI Contract (TDEFIC)</i>	<i>N</i>	<i>N</i>	<i>N</i>	<i>N</i>	<i>Y</i>
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)
TRICARE Retiree Dental Program (TRDP) Contractor	Y	N	N	N	N
Pharmacy Data Transaction System (PDTS) Contractor	N	N	N	N	Y
Designated Provider Contractors (DP)	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
National Quality Monitoring Contractor (NQMC)	N	N	N	N	Y
Team PRC (Contractor for Data Analysis for the Designated Provider Contracts)	N	N	N	N	Y
Global Overseas Remote Healthcare Contractor	N	N	N	N	Y

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ENTITY	COVERED ENTITIES			NON-COVERED ENTITY	BUSINESS ASSOCIATE OF THE TRICARE HEALTH PLAN?
	HEALTH PLAN?	PROVIDER?	CLEARING-HOUSE?	EMPLOYER?	
TRICARE Management Activity (TMA) - Supporting Systems: DEERS Deductible and Catastrophic Cap Data (DDCD), payment record databases (TEDs, TEPRVs, and TEPRCs Records), management databases (MHS Data Repository and its associated data marts)	N	N	N	N	Y
TRICARE Mail Order Pharmacy Contractor (TMOP)	N	Y	N	N	N
TRICARE Retail Pharmacy Benefits Contractor (TRPB)	N	N	N	N	Y
Regional Lead Agents	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

4.4.1.1. 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 Regulation, 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.

4.4.1.1.1. 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).

4.4.1.1.2. 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 Regulation 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: 1) 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 2) resolution of the standard transaction does not depend on the additional information.

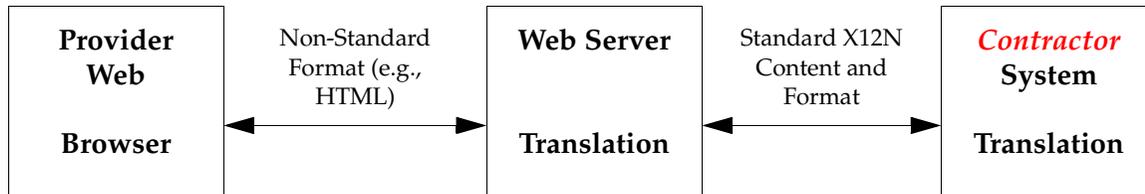
4.5.2. Web Server Technology

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 Regulation 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

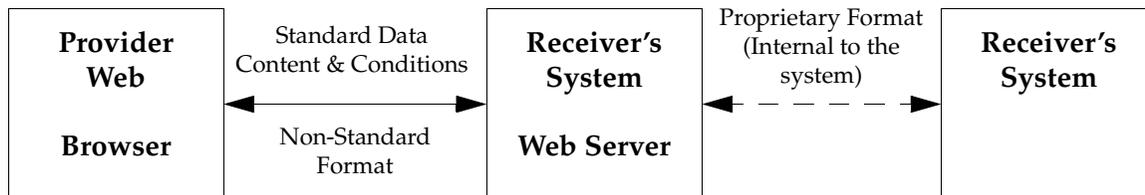
4.5.2.2. Browser-To-Web Server Data Exchange (not part of the receiver's system):

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.



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.



¹ This information was drawn from the Health Care Financing Administration 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 Health Care Financing Administration is now doing business as the Centers for Medicare and Medicaid Services (CMS).

4.6. Transactions Involving Foreign Entities

4.6.1. Electronic transactions from overseas Military Treatment Facilities (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 Military Treatment Facilities, 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 Military Treatment Facilities (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 Global Overseas Remote Healthcare 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, TRICARE Encounter Data Records (TEDs), TRICARE Encounter Provider Records (TEPRVs), And TRICARE Encounter Pricing Records (TEPRCs) - 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

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 Chapter 21, Addendum A 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.

5.1. Implementation Guide Requirements

5.1.1. *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.

5.1.2. Trading partner agreements shall NOT:

5.1.2.1. Modify the definition, condition, or use of a data element or segment in a standard Implementation Guide.

5.1.2.2. Add any additional data elements or segments to a standard Implementation Guide.

5.1.2.3. Utilize any code or data values, which are not valid to a standard Implementation Guide.

5.1.2.4. 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: 1) the interchange or “envelope” must be correct; 2) the transaction must be syntactically correct at the standard level; 3) the transaction must be syntactically correct at the implementation guide level; and 4) 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”

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, [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.

6.2.1. Currently, a “pay and chase” claim from a Medicaid State Agency is not a HIPAA covered transaction since the Transaction and Code Sets Regulation 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.

6.2.1.1. 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.

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

7.0. TRANSACTION TESTING

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

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

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

of contract compliant paper explanation of benefits (EOBs). It is expected that the *contractors* shall complete "cradle-to-grave" testing no later than 30 days prior to the start of *services*.

8.0. MISCELLANEOUS REQUIREMENTS

8.1. Paper Transactions

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

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

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

8.2. Attendance At Designated Standards Maintenance Organization (DSMO) Meetings And TMA CIO E-Health Meetings

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

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

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

8.2.4. When attending the DSMO meetings, *contractor* representatives shall work as a team and collaborate with other government and DoD/TRICARE representatives. *Contractor* representatives shall register under the Department of Defense/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.

8.2.5. *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.

8.2.6. Each *contractor* shall participate in the TMA Chief Information Officer (CIO) E-Health meetings. The E-Health meetings are held by teleconference for approximately 90 minutes every two months.

8.3. Provider Marketing

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

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

8.4. Data Retention And Audit Requirements

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

8.4.2. *Contractors* shall 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.

8.4.3. Transaction data is subject to audit by TMA, Regional Lead Agents, DoD, the Department of Health and Human Services 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.

