Chapter 19 Section 2

Standards For Electronic Transactions

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 Transaction and Code Sets Rule. On January 16, 2009, HHS published a Final Rule known as "Health Insurance Reform: Modifications to Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards." This Final Rule (referred to here as the "Modifications to HIPAA Electronic Standards Final Rule") adopted updated versions of the standards for electronic transactions that were originally adopted under the Administrative Simplification subtitle of HIPAA. Since 2009, HHS has published additional Final Rules for HIPAA initiatives which affect HIPAA transactions. As a HIPAA covered entity; TRICARE must comply with applicable adopted HIPAA rules.

On January 16, 2009, HHS also published a separate Final Rule adopting the International Classification of Diseases, 10th Revision (ICD-10) to replace the International Classification of Diseases, 9th Revision (ICD-9) in HIPAA transactions. This Final Rule, known as "HIPAA Administration Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS" (referred to here as "Modifications to Adopt ICD-10 Final Rule"), amends 45 CFR Parts 160 and 162.

On September 5, 2012, HHS published an additional Final Rule changing the compliance date for ICD-10 from October 1, 2013, to October 1, 2014. This Final Rule, known as "Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the ICD-10-CM and ICD-10-PCS Medical Data Code Sets" amends 45 CFR Part 162.

On April 1, 2014, President Obama signed and enacted "Protecting Access to Medicare Act of 2014" (H.R. 4302), which precludes ICD-10 codes from being adopted by HHS as the industry standard prior to October 1, 2015.

On August 4, 2014, HHS published a Final Rule setting October 1, 2015, as the new compliance date for ICD-10 implementation. This Final Rule, known as "Administrative Simplification: Change to the Compliance Date for International Classification of Diseases, 10th Revision (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets," amends 45 CFR Part 162.

1.1 Compliance Date

1.1.1 The contractor shall comply with the most current Final Rules on HIPAA adopted Electronic Transaction Standards, including compliance dates.

1.1.2 The contractor shall comply with the most current Final Rules on HIPAA adopted Transaction Operating Rules, including compliance dates.

1.1.3 The contractor shall comply with Final Rules on HIPAA adopted code sets (e.g., the use of International Classification of Diseases, Tenth Revision (ICD-10)), including compliance dates.

1.1.4 The contractor shall comply with Final Rules on HIPAA adopted identifiers (e.g., the use of Health Plan Identifiers (HPID)), including compliance dates.

1.2 Applicability

The contractor shall comply with HIPAA Electronic Standards Final Rules as the rules apply 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. These Rules refer to health plans, health care clearinghouses, and health care providers as "covered entities." The initial Transaction and Code Sets 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 and this designation has not changed in the Modifications to HIPAA Electronic Standards Final Rule.

1.3 Transaction Implementation Specification Standards

1.3.1 The contractor shall comply with the most current HIPAA Electronic Standards Final Rules, which adopt specifically stated HIPAA implementations of the ASC X12 standards, accompanying Errata, Addenda or Operating Rules. In the event that additional HIPAA adopted transactions, accompanying Errata, Addenda or Operating Rules are mandated for use in the future, TRICARE contractors shall comply with those HIPAA adopted transaction initiatives by the compliance dates specified by HHS in Final Rules.

1.3.2 For retail pharmacy electronic transactions covered under HIPAA, the contractor shall comply with HIPAA adopted National Council for Prescription Drug Programs (NCPDP) Telecommunication and Batch Standard Implementation Guides named and adopted by Final Rule.

1.3.2.1 The contractor shall accommodate use of both NCPDP and HIPAA ASC X12 837 Health Care Claim: Professional for billing retail pharmacy supplies and professional services.

1.3.2.2 The contractor shall accommodate use of the HIPAA adopted standard for the subrogation of pharmacy claims paid by Medicaid which is named and adopted in Final Rule as the NCPDP Batch Standard Medicaid Subrogation Implementation Guide. This standard is applicable to Medicaid agencies in their role as health plans, as well as to other health plans such as TRICARE that are covered entities under HIPAA.

1.3.3 The contractor shall comply with HIPAA related Final Rules associated with Section 1104 of the Administrative Simplification provisions of the Patient Protection and Affordable Care Act (PPACA) (hereafter referred to as the Affordable Care Act (ACA)). The ACA establishes new requirements for administrative transactions to improve the utility of the existing HIPAA transactions and reduce administrative costs (e.g., Standard Operating Rules).

1.3.4 HIPAA Adopted Code Set Standards

The contractor shall comply with HIPAA adopted code sets in accordance with Final Rules (e.g., International Classification of Diseases, 10th Revision (ICD-10)).

2.0 TRICARE OBJECTIVES

2.1 The TRICARE program shall be in full compliance with HIPAA Transactions, Code Sets and Identifiers Final Rules.

2.2 Private Care Systems shall be able to receive, process, and send compliant standard transactions where required.

3.0 CONTRACTOR RELATIONSHIPS TO THE TRICARE HEALTH PLAN (THP)

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.

- Is the transaction initiated by a covered entity or its business associate? If the answer is "no," then the standard does not apply and is not used. If "yes," then the standard applies and the next question needs to be answered.

- Is the transaction one the Secretary of HHS adopted as an adopted standard? If "no," the standard is not required by HIPAA to be used. If "yes," the standard shall be used.

3.3 To decide if a standard has been adopted for transaction, use the definition of the transaction as it is provided in the rule. Knowing who is and is not a business associate of the THP is important in determining where standard transactions shall be used within TRICARE. See Appendix B for the definition of "business associate."

3.4 The following table identifies TRICARE entities and their relationships to the THP.

ENTITY	COVERED ENTITIES			NON-COVERED ENTITY	BUSINESS ASSOCIATE OF THE THP?
	HEALTH PLAN?	PROVIDER?	CLEARING-HOUSE?	EMPLOYER?	
Department of Defense (DoD) (Army, Navy, Air Force, Marines, Space Force, Coast Guard*) *In time of war	N	N	N	Y	N

ENTITY	COVERED ENTITIES			NON-COVERED ENTITY	BUSINESS ASSOCIATE OF THE THP?
	HEALTH PLAN?	PROVIDER?	CLEARING-HOUSE?	EMPLOYER?	
THP (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), Enterprise Wide Referral and Authorization System (EWRAS), 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
Managed Care Support Contractors (MCSCs)	N	N	N	N	Y
TRICARE Dual Eligible Fiscal Intermediary 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 (ADDP) Contractor	Y	N	N	N	N
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
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 Overseas Program (TOP) Contractor	N	N	N	N	Y
Defense Health Agency (DHA) (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 (Military Health System (MHS)) Data Repository and its associated data marts)	N	N	N	N	Y
TRICARE Pharmacy (TPharm) Contractor	N	Y	N	N	Y
TRICARE Regional Offices (TROs)	N	N	N	N	Y
TRICARE Area Offices (TAOs)	N	N	N	N	Y

4.0 HIPAA 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, Errata, or Operating Rules named and adopted by the Secretary, HHS, as standards.

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 shall 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/Enhanced Multi-Service Markets (eMSMs) (CHCS and Referral Management System (RMS)))

4.2.1 HIPAA adopted transactions exchanged between contractors and providers must be in accordance with HIPAA standards.

4.2.2 The contractors shall be HIPAA-compliant with the following HIPAA adopted transactions, when HIPAA compliant usage applies:

4.2.2.1 Claims Transactions

[Receive Claims Transactions]

- The ASC X12N 837P - Health Care Claim: Professional, most currently adopted version.
- The ASC X12N 837I - Health Care Claim: Institutional, most currently adopted version.
- The ASC X12N 837D - Health Care Claim: Dental, most currently adopted version.
- **The most currently adopted version of NCPDP Telecommunication Standard and equivalent NCPDP Batch Standard** including claims for retail pharmacy supplies and professional services.

4.2.2.2 Coordination Of Benefits Transactions

[Receive 837 Coordination of Benefits Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, most currently adopted version.
- The ASC X12N 837 - Health Care Claim: Institutional, most currently adopted version.
- The ASC X12N 837 - Health Care Claim: Dental, most currently adopted version.

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, most currently adopted version.

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, most currently adopted version.

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, most currently adopted version.

4.2.2.6 Payment And Remittance Advice (RA) Transactions

[Send 835 Transactions]

- The ASC X12N 835 - Health Care Claim Payment/Advice, most currently adopted version.

4.2.2.7 Electronic Funds Transfer (EFT) and Remittance Advice (RA)

The contractors shall be able to send the following transmissions:

4.2.2.7.1 [Stage 1 Payment Initiation, Transmission of Health Care Payment/Processing Information]

Automated Clearing House (ACH) transmissions shall comply with the most current National Automated Clearing House Association (NACHA) requirements. The NACHA Rules are updated annually and govern every ACH payment, providing exact guidelines for securely storing, accessing and transmitting sensitive customer information. The contractor shall, when processing ACH transactions:

- Populate the ACH ENTRY DETAIL RECORD (6 Record, Field 10, Positions 79-79), with "1". The value "1" requires the ACH file to have an ADDENDA RECORD.
- Populate the ADDENDA RECORD (7 Record Field 3, Positions 4-83) with "Health Care Claim Payment/Advice (835)". The contractor may provide additional information in this field as needed.

4.2.2.7.2 [Stage 1 Payment Initiation, Transmission of Health Care RA]

- The ASC X12N 835 - Health Care Claim Payment/Advice, most currently adopted version.

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

4.3.1 HIPAA adopted transactions exchanged between contractors and other health plans (including TRICARE supplemental plans) shall be in accordance with HIPAA standards.

4.3.2 The contractors shall be able to receive, process, and send the following transactions with other health plans in accordance with HIPAA adopted Final Rule:

4.3.2.1 Coordination Of Benefits Transactions

[Send and Receive all 837 Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, most currently adopted version.
- The ASC X12N 837 - Health Care Claim: Institutional, most currently adopted version.
- The ASC X12N 837 - Health Care Claim: Dental, most currently adopted version.

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, most currently adopted version.

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, most currently adopted version.

4.3.2.4 Payment And Remittance Advice (RA) Transactions

[Send 835 Transactions]

- The ASC X12N 835 - Health Care Claim Payment/Advice, most currently adopted version.

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, most currently adopted version.

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, most currently adopted version.

4.3.2.7 Request to More Primary Payer for Payment Already Made by Subordinate Payer (Medicaid)

[Receive Medicaid Pharmacy Subrogation Transactions]

- NCPDP Batch Standard Medicaid Subrogation, most currently adopted version. The Modifications to HIPAA Electronic Standards Final Rule adopted a standard for the subrogation of pharmacy claims paid by Medicaid. This transaction is the Medicaid Pharmacy Subrogation Transaction. The standard for that transaction is the NCPDP Batch Standard Medicaid Subrogation Implementation guide. A Medicaid Pharmacy subrogation transaction is defined as the transmission of a claim from a Medicaid agency to a payer for the purpose of seeking reimbursement from the responsible health plan for a pharmacy claim the State has paid on behalf of a Medicaid recipient. This standard is applicable to Medicaid agencies in their role as health plans, but not to providers or health care clearinghouses because this transaction is not used by them. To the extent that Pharmacy Benefit Managers (PBMs) and claims processors are required by contract or otherwise to process claims on behalf of TRICARE, both shall receive the Medicaid Pharmacy Subrogation Transaction in the standard format.

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 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 and EWRAS)) 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/non-network providers and MTFs must be in standard format, unless subject to the exception in paragraph 1.7.2. 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

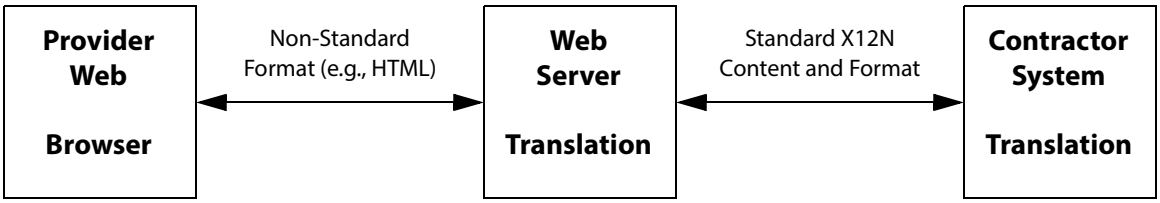
Note: This section discusses web server technology and, as a courtesy, provides guidance as to HIPAA requirements for the use of web applications. It is not an instruction from DHA to develop, operate, modify, or maintain contractor web applications. This section provides the HIPAA rules for operating web applications within the context of the Transaction and Code Sets Rule and provides DHA 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.

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.

[1] This information was drawn from the Health Care Financing Administration (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).

4.6.2.1 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 DHA

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

- The ANSI ASC X12N TA1 - Interchange Acknowledgment Segment.

6.1.2 Implementation Acknowledgment

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

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

6.1.3 Implementation Guide Syntax And Semantic And Business Edit Acknowledgments

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

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

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

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

6.2 Medicaid Non-Pharmacy Subrogation Claims

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

6.2.2 Currently, a subrogation non-pharmacy claim from a Medicaid State Agency is not a HIPAA covered transaction since the Transaction and Code Sets Rule defines a health care claim or

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

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

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

7.0 ONGOING TRANSACTION TESTING

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

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

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

7.2 Contractors shall test their capability to process standard transactions. This testing shall be "cradle-to-grave" testing from receipt of the transactions, through processing, and completion of all associated functions including creating and transmitting associated response transactions. Testing involving the receipt and processing of claims transactions shall also include the submission to and acceptance by the DHA of TED records and the creation of contract compliant paper Explanation Of Benefits (EOB). It is expected that the contractors shall complete "cradle-to-grave" testing no later than 30 days prior to the start of services.

8.0 MISCELLANEOUS REQUIREMENTS

8.1 Paper Transactions

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

8.1.2 Contractors may pay claims via electronic funds transfer or by paper check. The ASC X12N 835 Health Care Claim Payment/Advice transaction contains two parts, a mechanism for the transfer of dollars and one for the transfer of information about the claim payment. These two parts

may be sent separately. The 835 Implementation Guide allows payment to be sent in a number of different ways, including by check and electronic funds transfer. Contractors must be able to send the RA portion electronically but may continue to send payment via check.

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

8.2 Attendance At Designated Standards Maintenance Organization (DSMO) Meetings

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

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

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

8.2.5 Contractor representatives shall keep DHA 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/DHA should be aware. Each representative shall submit their reports to the DHA team lead within 10 work days following the DSMO meetings.

8.3 Provider Marketing

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

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

8.4 Data Retention And Audit Requirements

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

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

8.4.3 Transaction data is subject to audit by DHA, DoD, HHS, and other authorized government personnel. Contractors shall have the ability to retrieve and produce all electronic transaction data upon request from DHA (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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