

ALASKA TRADING PARTNER COMPANION GUIDE



Alaska Medical Assistance
&
**First Health Services
Corporation**



Alaska Trading Partner Companion Guide

Table of Contents

Disclaimer	4
Introduction	5
Purpose	6
Intended Audience	6
HIPAA Transaction Process	8
How to Use the Alaska Trading Partner Companion Guide	10
Transaction Overview	10
Medicaid Payments (Provider Certification)	11
HIPAA EDI Certification	12
Who to Contact for Answers	14
How to Get Started	15
Testing Procedures	16
Glossary	18
Appendix I	I-1
Trading Partner Electronic Transaction Submission Procedures	I-1
Appendix II	II-1
Alaska 837 Professional Instructions	II-1
Appendix III	III-1
Alaska 837 Institutional Instructions	III-1
Appendix IV	IV-1
Alaska 837 Dental Instructions	IV-1
Appendix V	V-1
Alaska 835 Payment/Advice Instructions	V-1
Appendix VI	VI-1
Alaska 270 Eligibility Benefit Inquiry Instructions	VI-1
Appendix VII	VII-1
Alaska 271 Eligibility Benefit Response Instructions	VII-1
Appendix VIII	VIII-1
Alaska 276 Claim Status Request Instructions	VIII-1

Alaska Trading Partner Companion Guide

<i>Appendix IX</i> _____	<i>IX-1</i>
Alaska 277 Eligibility Benefit Inquiry Instructions _____	IX-1
<i>Appendix X</i> _____	<i>X-1</i>
Alaska 278 Referral Certification and Authorization Request Instructions _____	X-1
<i>Appendix XI</i> _____	<i>XI-1</i>
Alaska 278 Referral Certification and Authorization Response Instructions _____	XI-1

Disclaimer

This document, and all associated materials, was developed as an aid for Alaska Medical Assistance providers to understand the federal obligations imposed by the Health Insurance Portability and Accountability Act (HIPAA) and is for informational use only. Neither the First Health Services Corporation (FHSC) nor the State of Alaska can provide any legal advice or statement of law regarding providers' obligations under federal law. The FHSC and the State of Alaska cannot warranty any information contained herein. As with any matter of law, independent legal counsel should be consulted regarding compliance with HIPAA.

Revision History (Introduction Section)

Date	Location	Revision
6/17/03	Entire guide (through Appendix IV)	Initial release
10/3/03	Table of Contents	Added Appendix V: Alaska 835 Payment/Advice Instructions
12/29/03	<ul style="list-style-type: none"> • Table of Contents • Revision History • Who to Contact for Answers 	<ul style="list-style-type: none"> • Modified page numbering format for appendices; added Appendix VI: Alaska 270 Eligibility Benefit Inquiry Instructions, Appendix VII: Alaska 271 Eligibility Benefit Response Instructions, Appendix VIII: Alaska 276 Claim Status Request Instructions, Appendix IX: Alaska 277 Claim Status Response Instructions, Appendix X: Alaska 278 Referral Certification and Authorization Request Instructions, and Appendix XI: Alaska 278 Referral Certification and Authorization Response Instructions • Created Revision History • Updated the phone number for ECCS Richmond to 1-800-924-6741
9/14/04	<ul style="list-style-type: none"> • HIPAA EDI Certification • Who to Contact for Answers • Testing Procedures 	<ul style="list-style-type: none"> • Added EVS phone number • Updated phone number, address, and fax number for FHSC Anchorage

Introduction

The Health Care Portability and Accountability Act (HIPAA) of 1996 requires that all “covered entities” submit compliant electronic transactions on or before October 16, 2003. The *Alaska Trading Partner Companion Guide* is intended to assist billers to successfully submit HIPAA-compliant electronic transactions to the State of Alaska Department of Health and Social Services. FHSC is the fiscal agent for the State of Alaska Medical Assistance programs and is contracted to process all transactions for trading partners.

The State of Alaska has opted to implement an interim solution for HIPAA compliance pending the development of a new HIPAA-compliant Medicaid Management Information System (MMIS). The interim solution will achieve HIPAA compliance with minimal changes to the current MMIS.

This guide is to serve as a supplement (i.e., a “companion”) to the *HIPAA ANSI X12N Implementation Guides* (including any approved addenda). This guide does not replace the laws, regulations, policies or procedures, including those outlined in the Alaska Medical Assistance Provider Billing Manuals and other official documents. These Implementation Guides and addenda are accepted by the Centers for Medicare and Medicaid Services (CMS) as the federal standard for electronic transactions.

Purpose

The purpose of the *Alaska Trading Partner Companion Guide* is to provide specific information regarding submission of electronic transactions in the federally acceptable ASC X12 formats to Alaska Medical Assistance. In order to achieve compliance with federally mandated standards for electronic data, Alaska Medical Assistance will implement the new electronic data interchange (EDI) transactions for its Medicaid Management Information System (MMIS). The specific instructions for each transaction are available as appendices to this overview. These include:

- 837 Health Care Claim: Dental
- 837 Health Care Claim: Professional
- 837 Health Care Claim: Institutional
- 835 Health Care Payment and Remittance Advice
- 270 Eligibility Benefit Inquiry
- 271 Eligibility Benefit Response
- 276 Claims Status Request
- 277 Claim Status Response
- 278 Referral Certification and Authorization

This document includes instructions to be used for the interim solution only. These instructions will be updated on the FHSC website as changes are implemented.

Intended Audience

The *Alaska Trading Partner Companion Guide* is designed for those providers and trading partners who want to exchange HIPAA-compliant electronic transactions with Alaska Medical Assistance, either

Alaska Trading Partner Companion Guide

directly or through a clearinghouse or third party biller. “Trading partners” are defined as entities that exchange HIPAA related electronic transactions.¹ This includes:

- Payers who choose to receive electronic transactions,
- Clearinghouses,
- Providers that directly send their claims (electronically) to payers, and
- Billers that send claims electronically to payers on behalf of providers.

¹ Renshaw, D. (2000). *A White Paper Describing the Business Issues and Recommended Solutions Associated with Trading Partner Agreements*. Strategic National Implementation Process (SNIP) White Paper, Workgroup for Electronic Data.

HIPAA Transaction Process

Figure 1 below depicts the basic process of electronic data interchange for providers who send their transactions directly to the FHSC translator. Once the transaction is submitted to FHSC, the system archive and the database will store all information provided, but will forward only limited information to the Medicaid Management Information System (MMIS) for processing. The system components will draw the required information to process the claim or transaction and send a response back through the translator to the provider who initiated the transaction. Please note that an 835 will only be generated if the provider has software capable of supporting that transaction.

Figure 1. HIPAA Transaction Process for Providers Submitting Directly

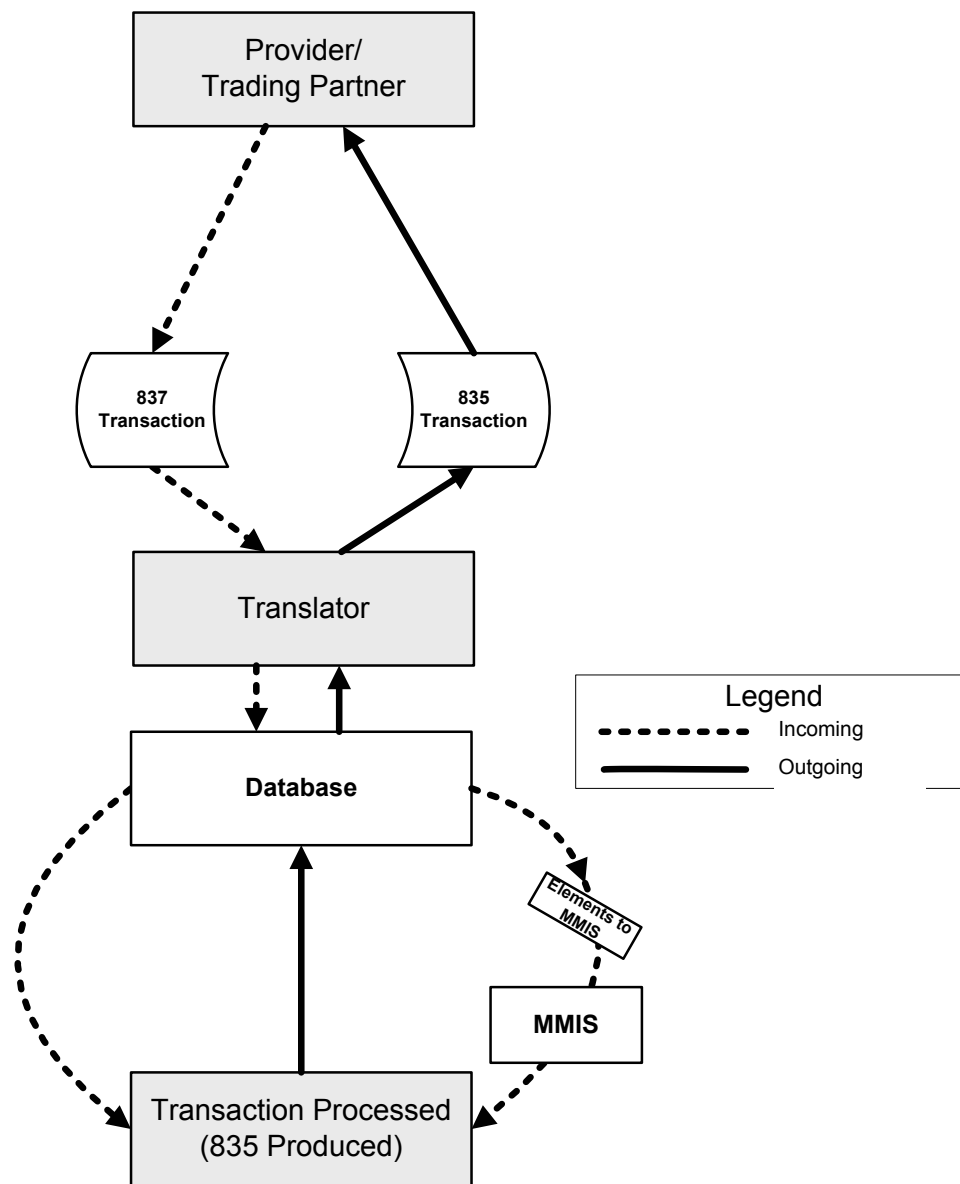
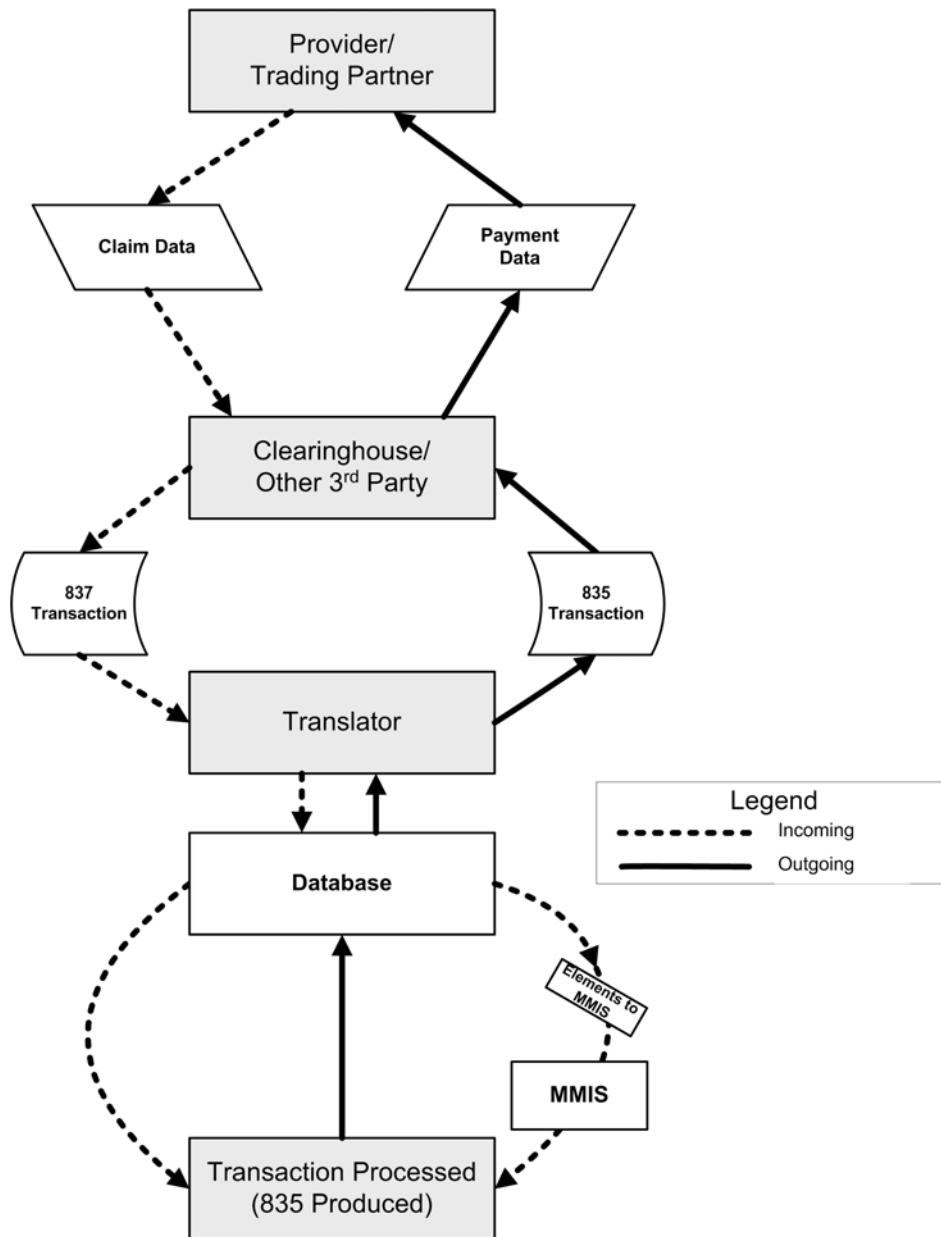


Figure 2 illustrates the data flow when providers choose not to send their transactions directly, but to utilize a clearinghouse or third party submitter. The clearinghouse/third party transforms the information supplied by the provider into the required transaction standard formats based on the information provided. The process is then identical to the one outlined earlier, except that a response will be sent back through the translator to the clearinghouse/third party submitter. Please note that an 835 will only be generated if the clearinghouse/third party submitter is capable of supporting that transaction.

Figure 2. HIPAA Transaction Process for Providers
Using a Clearinghouse or other 3rd Party



How to Use the Alaska Trading Partner Companion Guide

The tables that detail each transaction (see appendices) are directed toward staff who are responsible for the implementation of Electronic Data Interchange (EDI) for providers/trading partners. It is essential that staff obtain copies of the *ANSI X12N Implementation Guides* (referred to as Implementation Guides throughout this document) and all relevant addenda. These guides can be downloaded at no cost from The Washington Publishing Company at www.wpc-edi.com.

The Implementation Guides are considered the federal standard for EDI. Staff should use the *Alaska Trading Partner Companion Guide* to clarify information specific to submission of electronic transactions to Alaska Medical Assistance. In case of a conflict between the Implementation Guides and the *Alaska Trading Partner Companion Guide*, the Implementation Guides should be regarded as the final authority.

Each HIPAA Transaction that will be supported by Alaska Medical Assistance is addressed in this guide. Instructions for each individual transaction are contained in a separate Appendix allowing for ease of reference. All documents associated with the *Alaska Trading Partner Companion Guide* will be available online at the First Health Services Corporation website: <http://alaska.fhsc.com/hipaa/>.

Transaction Overview

There are nine (9) identified HIPAA transactions. Based on the business needs of the Alaska Medical Assistance Program and its trading partners, only the following transactions are being implemented in the interim solution:

- *Health Care Claim (X12N 837 I, P, D)*
The purpose of this transaction is to request payment for health care services and provide necessary accompanying information.
- *Health Care Payment and Remittance Advice (X12N 835)*
The purpose of this transaction is to notify the providers of the results of claims processing and provide remittance advice and explanation of benefits information.
- *Eligibility Benefit Inquiry and Response (X12N 270/271)*
The purpose of this transaction pair is to request information regarding a recipient, which can include eligibility, coverage, or benefits, and to receive a response to the inquiry.
- *Referral Certification and Authorization (X12N 278)*
The purpose of this transaction is to either request prior authorization for health care or to obtain authorization for referring an individual to another provider and then receive a response to the request.
- *Claim Status Request and Response (X12N 276/277)*
The purpose of this transaction pair is to make an inquiry regarding the status of health care claims and to receive a response.

Medicaid Payments (Provider Certification)

When any provider of services submits a claim to Alaska Medical Assistance, that individual ensures that the information furnished is true and accurate. This remains consistent for electronic claims, whether submitted directly or through a billing service or clearinghouse. The following information is relevant to segments within the electronic Health Care Claim (837) transactions:

CLM06-Provider or Supplier Signature Indicator

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payment claimed for providing such services as the State Agency or Department of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment, or similar cost-sharing charge.

Signature of Physician (or Supplier) I certify that the services listed were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

CLM07-Provider Accept Assignment

CLM08 – Benefits Assignment Certification Indicator

All providers who participate in the Alaska Department of Health and Social Services Medical Assistance programs agree to accept assignment for the services they render and bill for eligible recipients who show proof of eligibility at the time services are rendered. Providers are the only entity that may be reimbursed for covered services to eligible recipients. It is expected that most claim submissions will indicate that assignment is accepted, however, providers may indicate “not assigned” in the following circumstances:

- Patient paid all or part of the claim prior to eligibility determination
- Patient failed to show proof of eligibility at the time services were rendered
- Provider is billing for a service that is not covered by Alaska Medical Assistance

CLM09 – Release of Information

CLM10 – Patient Signature Source Code

All recipients who participate in the Alaska Department of Health and Social Services Medical Assistance programs agree to authorize the release of medical data between the provider and the department when they apply for the program. It is therefore unnecessary for providers to secure a separate signature from the patient at the time of each health care delivery encounter. Additionally, HIPAA privacy rules do not require release of information for treatment, payment, and health care operations. The expected response for this segment is “Y”, but other responses will also be accepted for claims processing.

HIPAA EDI Certification

Purpose: Certification is designed to ensure that electronic claims and other transactions submitted by providers or their billing agents are HIPAA-compliant and compatible with the Alaska Medical Assistance system.

Definition: The Alaska Medical Assistance program defines “certification” as documentation from a nationally recognized HIPAA certification entity for a minimum of the first four of the total seven types of testing as provided in the WEDI-SNIP White Paper.

The Types of Transaction Compliance and Certification Testing include:

- Type 1: EDI Syntax and Integrity Testing
- Type 2: HIPAA Syntactical Requirement Testing
- Type 3: Balancing
- Type 4: Situation Testing
- Type 5: External Code Set Testing
- Type 6: Product Types or Lines of Services
- Type 7: Implementation Guide-Specific Trading Partners

Below are the Alaska Medical Assistance Program guidelines for HIPAA transaction certification:

1. Certification is **required** for all clearinghouses, software vendors, and any billing services or other business agents submitting HIPAA-compliant transactions directly to Alaska Medical Assistance or their designee on behalf of providers.
2. Certification is **strongly recommended** for providers submitting HIPAA-compliant transactions directly to Alaska Medical Assistance on their own behalf. Any providers that have successfully tested with another health plan may ask Alaska Medical Assistance to remove the certification requirement *if adequate documentation of successful testing can be provided*. Adequate documentation means written verification from a major commercial payer (e.g., Blue Cross) or government payer (e.g., Medicare), demonstrating that testing with the payer has been successful. The adequacy of the documentation submitted will be determined at the discretion of the Department of Health and Social Services, Medical Assistance Program.

Documentation demonstrating HIPAA certification or documentation demonstrating successful testing with a major commercial payer should be submitted to:

ECCS Anchorage
First Health Services Corporation
P.O. Box 240807
Anchorage AK 99524-0807
Fax: (907) 644-8126

First Health Services Corporation will provide technical assistance to trading partners in their efforts to successfully test their HIPAA compliant transactions with Alaska Medical Assistance. If, after reasonable efforts, the transactions continue to fail testing, the trading partner may be required to become certified before testing will continue. Reasonable efforts will be defined on a case by case basis, and will depend on the level of technical assistance necessary and the time required to assist the trading partner with testing attempts. Generally, if testing is not 100% successful within 30 days, certification will be required.

Software Vendors/Billing Services and Clearinghouses

Software Vendors

A software vendor supplies software and support services to the provider community. If a vendor advertises a HIPAA-compliant solution software, please be aware that each HIPAA-compliant solution will require customization for each payer. The software product you choose should be capable of electronic claims submission to the Alaska Medical Assistance Program.

You may want to ask your practice management consultant (if you have one) to recommend a qualified dealer or software system, or consult with your colleagues in similar practices about their experiences with vendors and software products.

Billing Services/Clearinghouses

Billing services and clearinghouses are services that are designed to insure that your transactions and claims are HIPAA-compliant prior to submission to the Alaska Medical Assistance Program and other third party carriers. In most cases a per-claim/transaction fee is charged.

Billing services and clearinghouses usually edit claims for accuracy, format and completeness, and the claims are distributed to the appropriate carriers.

PayerpathSM

First Health Services Corporation currently accepts electronic claims through an internet-based claims management system (clearinghouse) called PayerpathSM (<http://www.payerpath.com/>) at no cost to the provider. PayerpathSM assists trading partners with submission of HIPAA-compliant transactions by performing the following functions:

- Receives a non-standard transaction (for example, non-standard format and/or non-standard data content) from a provider and translates it into a standard transaction for transmission to a payer.
- Receives a standard transaction from a payer and translates it into a non-standard transaction (for example, non-standard format and/or non-standard data content) for return transmission to a provider.

Who to Contact for Answers

Topic	Organization	Department	Phone Number
Regulation Interpretation	Centers for Medicare & Medicaid Services (Transactions & Code Sets) <i>(www.cms.hhs.gov/hipaa)</i>	CMS HIPAA Administrative Simplification Hotline	(866) 282-0659
Privacy & Security	Office of Civil Rights (federal) <i>(www.hhs.gov/ocr/hipaa)</i> Department of Health and Social Services (State) <i>(www.hss.state.ak.us)</i>	Division of Administrative Services	(877) 696-6775 (907) 465-4722
General HIPAA Information	First Health Services Corp <i>(http://alaska.fhsc.com)</i>	Provider Inquiry	(907) 644-6800 or (800) 770-5660 (toll free in Alaska)
Companion Guides	First Health Services Corp <i>(http://alaska.fhsc.com)</i>	Electronic Commerce Customer Support (ECCS)	(800) 924-6741
Trading Partner Agreements	First Health Services Corp <i>(http://alaska.fhsc.com)</i>	ECCS Anchorage	(907) 644-6800 or (800) 770-5660 (toll free in Alaska)
Testing	First Health Services Corp <i>(http://alaska.fhsc.com)</i>	ECCS	(800) 924-6741
EDI Technical Support	First Health Services Corp <i>(http://alaska.fhsc.com)</i>	ECCS	(800) 924-6741
Claims Processing & Billing Questions	First Health Services Corp <i>(http://alaska.fhsc.com)</i>	Provider Inquiry	(907) 644-6800 or (800) 770-5660 (toll free in Alaska)
Automated Eligibility Verification System	First Health Services Corp <i>(http://alaska.fhsc.com)</i>		(800) 884-3223 (available 24 hours per day)

How to Get Started

If you are a provider or trading partner who currently bills Alaska Medical Assistance claims electronically, Figure 3 details the process for transitioning to the submission of HIPAA-compliant transactions. The same process would apply to providers who currently bill Alaska Medical Assistance on paper claim forms and would like to bill electronically.

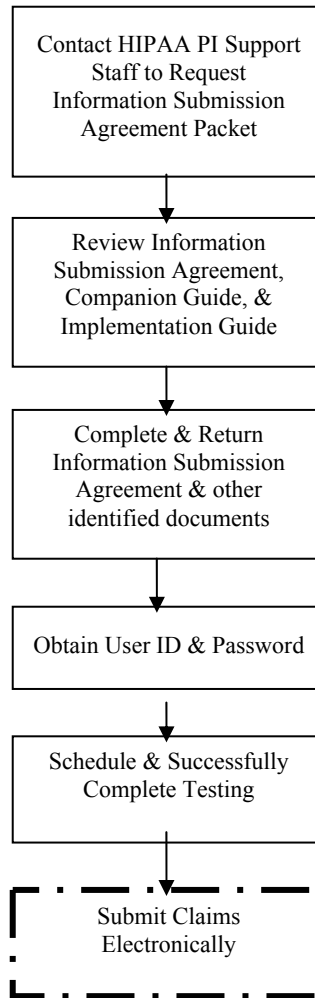


Figure 3. Trading Partner Application Process

Testing Procedures

All trading partners **must test each type of electronic transaction** they plan to submit to Alaska Medical Assistance (e.g., 837 Health Care Claim). Testing will help ensure compliance with HIPAA requirements for both incoming and outgoing transactions in the data interchange.

The table below outlines the projected months that testing will begin for each supported transaction by Alaska Medical Assistance. Prior to beginning testing, each trading partner will be required to complete the following forms:

1. *Provider Information Submission Agreement Form* – Any provider that plans to submit HIPAA-compliant transactions directly to the Alaska Medical Assistance program will be required to complete this form prior to transaction testing.
2. *Billing Agent Information Submission Agreement Form* – Any third party submitter (clearinghouse, billing service, etc.) that plans to submit HIPAA-compliant transactions to the Alaska Medical Assistance program will be required to complete this form prior to transaction testing.

For more information regarding submission agreements and/or testing procedures, please contact the ECCS Anchorage at (907) 644-6800 or (800) 770-5660 (toll free in Alaska).

The table below represents the tentative schedule for trading partners (billing agents) to begin testing HIPAA-compliant transactions. For more in-depth procedures about submission of electronic transactions, please refer to Appendix I of this document, entitled “Trading Partner Electronic Transaction Submission Procedures” for details.

Transaction	Month
1. 270/271 – Eligibility inquiry/response	July
2. 837 (all) – Health care claim/encounter	July
3. 276/277 – Claim status inquiry/response	July
4. 278 – Prior Authorization	July
5. 835 – Remittance Advice	July

Alaska Trading Partner Companion Guide

Figure 4 illustrates the testing process for each transaction that a Trading Partner plans to submit to Alaska Medical Assistance. Successful testing is required for each transaction supported. As each transaction is tested, the trading partner will be notified of its status. Once successful testing is completed for a transaction, it will be determined if any other transactions require testing. If no further testing is required, then a formal notification will be sent identifying all transactions that were successfully tested with Alaska Medical Assistance. The notification will also identify the date that transactions can be sent for production.

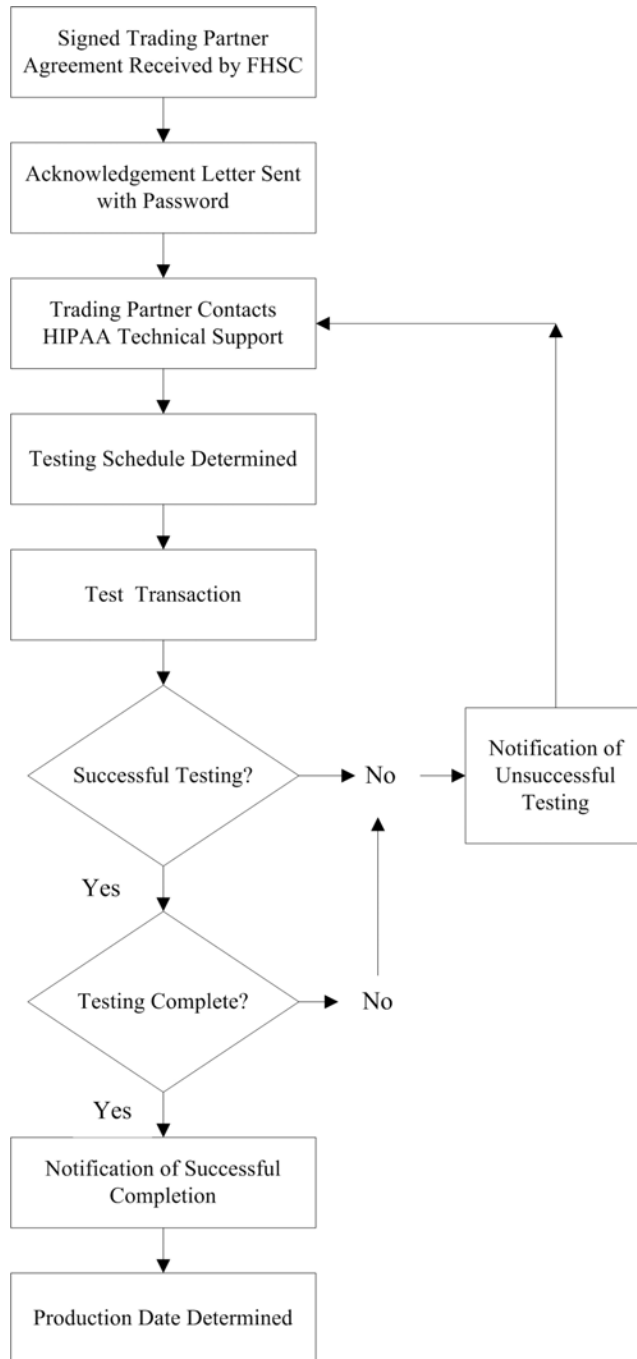


Figure 4. Trading Partner Test and Go Process

Glossary

American National Standards (ANS): Standards developed and approved by organizations accredited by ANSI.

American National Standards Institute (ANSI): The organization that accredits various standards setting committees and monitors their compliance with the open rule-making process that they must follow to qualify for ANSI accreditation. HIPAA prescribes that the standards mandated under it be developed by ANSI accredited bodies whenever practical. X12 is the format of the transaction code sets.

Business Associate (BA): A person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right.

Business Partner (BP): A term used in HIPAA Privacy NPRM to identify organizations that perform business functions for a covered entity, and should therefore be required to accept the same obligations for protecting any individually identifiable health care information that they receive from covered entity.

Chain of Trust (COT): A term used in the HIPAA Security NPRM for a pattern of agreements that extend protection of health care data by requiring that each covered entity that shares health care data with another entity require that entity provide protections comparable to those provided by the covered entity, and that entity, in turn, require that any other entities with which it shares the data satisfy the same requirements.

Claim Adjustment Reason Codes: A national administrative code set that identifies the reasons for any differences, or adjustments, between the original Provider charge for a claim or service and the payer's payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim transactions, and is maintained by the Health Care Code Maintenance Committee.

Claim Attachment: Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.

Code Set: Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions.

Code Set Maintaining Organization: Under HIPAA, this is an organization that creates and maintains the code sets adopted by the Secretary for use in the transactions for which standards are adopted. Also see Part II, 45 CFR 162.103.

Coordination of Benefits (COB): A process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called a crossover.

Covered Entity (CE): Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

Designated Code Set: A medical code set or an administrative code set that HHS has designated for use in one or more of the HIPAA standards.

Alaska Trading Partner Companion Guide

Designated Standard Maintenance Organization (DSMO): An organization that the Secretary has designated to maintain the standards; receive and process requests for adopting a new standard or modifying an adopted standard.

Electronic Commerce Customer Support (ECCS): A division of First Health Services Corporation which maintains, monitors, and coordinates all FTP file transfers between trading partners and First Health Services Corporation. They assign logon IDs and original passwords for all FTP submitters. They also perform a help desk function for questions concerning receipt of files, what data was in the file, and whether the file was accepted and processed. ECCS can be contacted at (888) 829-5373, Option 2.

Electronic Data Interchange (EDI): This usually means X12 and similar variable length formats for the electronic exchange of structured data. It is sometimes used more broadly to mean any electronic exchange of formatted data.

HCFA Common Procedural Coding System (HCPCS): A medical code set that identifies health care procedures equipment and supplies for claim submission purposes. It has been selected for use in the HIPAA transactions. HCPCS Level I contain numeric CPT codes that are maintained by the AMA. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set.

These are maintained by HCFA, the BCBSA, and the HIAA. HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II. These are usually called local codes and must have a W, X, Y, or Z in the first position. HCPCS Procedure Modifier Codes can be used with all three levels, with the WA - ZY range used for locally assigned procedure modifiers. (It is the HCPCS Level III or local codes which will not be available to use under HIPAA standardization.)

Health Care Clearinghouse: Under HIPAA, this is an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, K2, or Public Law 104-191.

Health Level Seven (HL7): An ANSI accredited group that defines standards for the cross platform exchange of information within a health care organization. HL7 is responsible for specifying the Level Seven OSI standards for the health industry. The X12 275 transaction will probably incorporate the HL7 CRU message to transmit claim attachments as part of a future HIPAA claim attachments standard. The HL7 Attachment SIG is responsible for the HL7 portion of this standard.

Local Code(s): A generic term for code values that are defined for a state or other political subdivision, or for a specific payer. This term is most commonly used to describe HCPCS Level III Codes, but also

Alaska Trading Partner Companion Guide

applies to state assigned Institutional Revenue Codes, Condition Codes, Occurrence Codes, Value Codes, etc.

Medicaid: Title XIX of the Social Security Act is a program which provides medical assistance for certain individuals and families with low incomes and resources. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons.

National Association of State Medicaid Directors (NASMD): An association of state Medicaid directors. NASMD is affiliated with the American Public Health Human Services Association (APHSA). The Nation Medicaid EDI-HIPAA (NMEH) has been implemented under this organization to work on the EDI related HIPAA provisions.

National Committee on Vital and Health Statistics (NCVHS): A Federal advisory body within HHS that advises the Secretary regarding potential changes to the HIPAA standards.

National Council for Prescription Drug Programs (NCPDP): An ANSI accredited group that maintains a number of standard formats for use by the retail pharmacy industry, some of which are included in the HIPAA mandates.

National Drug Code (NDC): A medical code set that identifies prescription drugs and some over the counter products, and that has been selected for use in the HIPAA transactions.

National Employer ID: A system for uniquely identifying all sponsors of health care benefits.

National Uniform Billing Committee (NUBC): An organization, chaired and hosted by the American Hospital Association, that maintains the UB 92 hardcopy institutional billing form and the data element specifications for both the hardcopy form and the 192 byte UB 92 flat file EMC format. The NUBC has a formal consultative role under HIPAA for all transactions affecting institutional health care services.

National Uniform Claim Committee (NUCC): An organization, chaired and hosted by the American Medical Association, that maintains the HCFA 1500 claim form and a set of data element specifications for professional claims submission via the HCFA 1500 claim form, the Professional EMC NSF, and the X12 837. The NUCC also maintains the Provider Taxonomy Codes and has a formal consultative role under HIPAA for all transactions affecting non dental non institutional professional health care services.

Office for Civil Rights: The HHS entity responsible for enforcing the HIPAA privacy rules.

Provider Taxonomy Codes: An administrative code set for identifying the Provider type and area of specialization for all health care providers. A given Provider can have several Provider Taxonomy Codes. This code set is used in the X12 278 Referral Certification and Authorization and the X12 837 Claim transactions, and is maintained by the NUCC.

Standard Transaction: Under HIPAA, this is a transaction that complies with the applicable HIPAA standard.

Standard Setting Organization (SSO): See Part II, 45 CFR 160.103. This is an organization accredited by ANSI that develops and maintains standards for information transaction or data elements, or any other standard necessary to implement the Electronic Transaction rule.

Strategic National Implementation Process (SNIP): A WEDI program for helping the health care industry identify and resolve HIPAA implementation issues.

Alaska Trading Partner Companion Guide

Trading Partner Agreement (TPA): Under HIPAA, this is an agreement related to the exchange of information in electronic transaction, whether the agreement is distinct or part of a larger agreement, between each party to the agreement.

Transaction: Under HIPAA, this is the exchange of information between two parties to carry out financial or administrative activities related to health care.

Value-Added Network (VAN): A vendor of EDI data communications and translation services.

Washington Publishing Company (WPC): The company that publishes the X12N HIPAA Implementation guides and the X12N HIPAA Data Dictionary, and that also developed the X12 Data Dictionary.

Workgroup for Electronic Data Interchange (WEDI): A health care industry group that lobbied for HIPAA A/S, and that has a formal consultative role under the HIPAA legislation. WEDI also sponsors SNIP.

X12: An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are X12 standards.

X12 148: The X12 First Report of Injury, Illness, or Incident transaction. This standard could eventually be included in the HIPAA mandate.

X12 270: The X12 Health Care Eligibility & Benefit Inquiry transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 271: The X12 Health Care Eligibility & Benefit Response transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 275: The X12 Patient Information transaction. This transaction is expected to be part of the HIPAA claim attachments standard.

X12 276: The X12 Health Care Claims Status Inquiry transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 277: The X12 Health Care Claim Status Response transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates. This transaction is also expected to be part of the HIPAA claim attachments standard.

X12 278: The X12 Referral Certification and Authorization transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 820: The X12 Payment Order & Remittance Advice transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 834: The X12 Benefit Enrollment & Maintenance transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12 835: The X12 Health Care Claim Payment & Remittance Advice transaction. Version 4010A1 of this transaction has been included in the HIPAA mandates.

Alaska Trading Partner Companion Guide

X12 837: The X12 Health Care Claim or Encounter transaction. This transaction can be used for institutional, professional, dental, or drug claims. Version 4010A1 of this transaction has been included in the HIPAA mandates.

X12N: A subcommittee of X12 that defines EDI standards for the insurance industry, including health care insurance.

Source: Workgroup for Electronic Data Interchange (WEDI)