Important Definitions and Acronyms

835 - An electronic transaction, also known as an Electronic Remittance Advice (ERA): The ERA provides itemized reasons for payments, adjustments and denials.Information about final claims determination is displayed in the HIPAA-mandated standard format.

837I - Electronic Transaction, Institutional Claim: The 837I is the standard format used by institutional providers to transmit health care claims electronically.

837P - Electronic Transaction, Professional Claim: The 837P is the standard format used by health care professionals and suppliers to transmit health care claims electronically.

277CA - Electronic Transaction, Claim Acknowledgement: The 277CA provides a claim-level acknowledgement of all claims received for pre-processing bythe payer, including detailed information about claims that have received edits anda summary of all accepted and rejected claims.

Accepted: Claims are considered accepted once they are received and pre-processed without edits. Accepted claims are reported on the 277CA transaction.

Attachment Control Number (ACN): An arbitrary number assigned by claim submitters to link 837 I/P claim transactions with Claim Attachment Forms. The ACN is located in the 2300 loop/PWK segment of the 837 I/P transactions and theClaim Attachment Form. When Aspirus Health Plan   receives an 837 I/P transaction containing an ACN, we match it to the corresponding Claim Adjustment Form using the ACN value.

American National Standards Institute (ANSI): ANSI promotes and coordinates the U.S. voluntary consensus standards, provides a neutral forumfor the development of policies on standards issues and ensures integrity is maintained.

Accredited Standards Committee (ASC) X12: A group of standards supported by the American National Standards Institute (ANSI) creates consistent standard data elements for health care transactions such as claims and   encounters, eligibility inquiries and responses, claim status inquiries and responses, referrals and prior authorizations, and health care payment and remittance advice. ASC X12assists several organizations in the maintenance and distribution of code lists external to the X12 family of standards. The lists are maintained by the Centers forMedicare and Medicaid Services (CMS), The National Uniform Claim Committee (NUCC) and committees that meet during standing X12 meetings (ANSI Group, CARC and RARC codes etc.)

Change Healthcare: Aspirus Health Plan selected Change Healthcare as its primary clearinghouse and pre-adjudication software partner to manage EDI connectivity in aneffort to expand electronic services for providers (e.g., real-time services) as well as support administrative simplification, administrative cost reduction and regulatory compliance initiatives. Change Healthcare contact information is located at: https://www.changehealthcare.com/contact

Claim Adjustment Group Code: The Claim Adjustment Group Codes are internal to the X12 standard. Group codes identify the financially responsible party or the general category of payment adjustment. The format is always two alpha characters.
CO - Contractual Obligation (assigns responsibility to the provider)
CR - Corrections and Reversal Note: This value is not to be used with 005010 and up OA - Other Adjustment PI - Payer Initiated Reductions
PR - Patient Responsibility (assigns responsibility to the patient)

Claim Adjustment Reason Codes (CARC): Claim adjustment reason codes communicatean adjustment, meaning that they must communicate why a claim or service line was paiddifferently than it was billed. CARCs and RARCs are updated three times a year. You can view the latest codes at https://www.x12.org

Claim Frequency Type Code (CFTC): Code specifying the frequency of the claim (this is the third position of the Uniform Billing Claim Form Bill Type now allowed on professional claims). The CFTC may also be used in 837P claims, which maps to box 7 of the CMS-1500 claim form. The corresponding values are:

1 - ORIGINAL (Admit thru Discharge Claim)
7 - REPLACEMENT (Replacement of Prior Claim) 8 - VOID
(Void/Cancel of Prior Claim)

Electronic Claims Attachments: Supplemental documents that provide additional information related to claims processing such as medical records, coordination of benefitsor additional information related to unlisted codes.

Electronic Data Interchange (EDI): The exchange of data in a standard electronic format that follows specific data content rules between a health care provider and Aspirus Health Plan, or between Aspirus Health Plan and another health care plan. Thetransfer may take place with the assistance of a clearinghouse or billing service that represents a provider of health care or another payer. EDI transactions are transferredvia computer either to or from Aspirus Health Plan.

Electronic Funds Transfer (EFT): Aspirus Health Plan offers Electronic Funds Transfer(EFT). Provider should contact the Provider Assistance Center at 1-855-931-4852 to change enrollmentsfor EFT.

Health Insurance Portability and Accountability Act (HIPAA): The Health Insurance Portability and Accountability Act of 1996 prompted new Federal regulations that require physicians to ensure they are protecting the privacy and security of patients'medical information and using a standard format when submitting electronic transactions,such as submittingclaims to payers.

Loop: Loops are ASC X12-defined sections of data within electronic transactions, each loop having a specific focus. For instance, the 837P claim transaction must include the following loops: Header, Submitter Name (1000A), Receiver Name (1000B), Billing/Pay-to Provider Hierarchical Level (2000A), Billing Provider Name (2010AA), Subscriber Hierarchical Level (2000B), Subscriber Name (2010BA), Payer Name (2010BB), Claim Level Information(2300)and Service Level Information(2400).

National Provider Identifier (NPI): A unique, 10-digit number required in ASC X12 transactions to identify "health care providers" as defined by the Health Insurance Portability and Accountability Act **(**HIPAA). NPI values are assigned for both individuals (known as a "Type 1 NPI") and organizations (known as a "Type 2 NPI"). Aspirus HealthPlan will not accept an alternative identifier when an NPI is required.

National Uniform Claim Committee (NUCC): NUCC was created in 1995 to develop a standardized data set for use by the non-institutional health care community to transmit claim and encounter information. The NUCC is intended to have an authoritative voice regarding national standard content and data definitions for non-institutional health care claims in the United States.

Remittance Advice Reason Codes (ASC) X12 External Code Sets (RARC): Remittance Advice Remark Codes (RARCs) are used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing. Each RARC identifies a specific message as shown in the Remittance Advice Remark Code List. CARCs and RARCs are updated three times a year. You can view the latest codes at https://www.x12.org

Segment: Segments are ASC X12-defined data records within electronic transactions. Segments are associated with specific loops and report detailed information related to the transaction.

Transaction Control Number (TCN): Claim number assigned by Aspirus Health Plan on accepted claim submissions. Aspirus Health Plan uses the claim number to track the status of the claim through processing and payment. In the 835 transaction, Aspirus Health Plan reports the TCN in loop 2100/segment CLP07.

WPC-ASC X12 External Code Sets: Published for ASC X12's Insurance Subcommittee, X12N provides documentation adopted under the Health Insurance Portability and Accountability Act (HIPAA) and other related, value-added documents, such as the Health Care Code lists (ANSI X12 CARC & RARC). https://www.x12.org

Questions?

If you have further questions, please call Aspirus Health Plan's Provider Assistance Center at 715-631-7412 or 1-855-931-4851 toll free.