

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 by the payer, including detailed information about claims that have received edits and a 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 8371/P claim transactions with AUC Claim Attachment Forms. The ACN is located in the 2300 loop/PWK segment of the 8371/P transactions and the AUC Claim Attachment Form. When UCare receives an 8371/P transaction containing an ACN, we match it to the corresponding AUC 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 forum for 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 X12 assists several organizations in the maintenance and distribution of code lists external to the X12 family of standards. The lists are maintained by the Centers for Medicare 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.).



Administrative Uniformity Committee (AUC): The AUC is a voluntary, broad-based group representing Minnesota health care public and private payers, hospitals, physicians, other providers and State agencies.

<https://www.health.state.mn.us/facilities/auc/>

- [Minnesota Uniform Companion Guides Version 5010 and D.Ø](#)
- [Minnesota AUC best practices](#)
- [Minnesota AUC coding recommendations](#)
- [Minnesota AUC forms](#)

Change Healthcare (formerly RelayHealth): UCare selected Change Healthcare as its primary clearinghouse and pre-adjudication software partner to manage EDI connectivity in an effort 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 communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. CARCs and RARCs are updated three times a year. You can view the latest codes at <http://www.wpc-edi.com/reference>

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 22 of the CMS-1500. 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 benefits or 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 UCare, or between UCare and another health care plan. The transfer 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 transferred via computer either to or from UCare.

Electronic Funds Transfer (EFT): Electronic deposit of provider payments directly into the provider's bank account. Providers register online at UCare.org for [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 submitting claims 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).

Minnesota State Statute, section 62J.536: Statute that requires all Minnesota health care providers to submit all health care claims electronically, including secondary claims, using a standard format. This statute applies to all UCare members enrolled in Minnesota Health Care Programs (Prepaid Medical Assistance Program, MinnesotaCare, Minnesota Senior Care Plus, Minnesota Senior Health Options, *UCare Connect* and *UCare Connect+Medicare*) Medicare products (*UCare for Seniors* and *EssentiaCare*), and *UCare Choices*. UCare can only accept paper claims for services rendered by providers outside of Minnesota.

MN-Econnect/HealthEC: Direct Date Entry vendor for providers to submit claims via EDI. Providers are required to register directly with HealthEC in order to transmit electronic claims to UCare. The web service is funded by the Minnesota health plans at no cost to providers for electronic claims filing.

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"). UCare 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 (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 <http://www.wpc-edi.com/reference/>

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 UCare on accepted claim submissions. UCare uses the claim number to track the status of the claim through processing and payment. In the 835 transaction, UCare reports the TCN loop 2100/segment CLP07.

Unique Minnesota Provider Identifier, UMPI: The Health Insurance Portability and Accountability Act (HIPAA) regulations require "health care providers" to acquire an NPI for identifying themselves in ASC X12 electronic transactions. Providers who do not qualify as a "health care provider" under HIPAA, also known as "atypical providers," may be assigned a similar identifier by the state of Minnesota known as Unique Minnesota Provider Identifiers (UMPIs). UCare will not accept an alternative rendering provider identifier when an UMPI is required (e.g., where rendering provider is a personal care attendant or home health billing for personal care attendant services).

Washington Publishing Company (WPC): Exclusive publisher for ASC X12's Insurance subcommittee, X12N. WPC 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).