Glossary

Accredited Standards Committee (ASC) X12
A group of government and industry members chartered by ANSI to develop national electronic standards for submission to ANSI for subsequent approval and dissemination.

Activity Report
Generated by the Gateway to inform the sender that the transmission was successful and also identifies the file type sent (NSF, UB-92).

Adjudication
A process in which a claim passes through a series of edits to determine proper payment liability.

AdminaStar Federal, Inc (ASF)
An Anthem affiliate contracted by CMS (Centers for Medicare and Medicaid services) to process Medicare Part A (Intermediary) transactions for KY, IL, IN, OH; Medicare Part B (for Region B (IL, IN, OH, MD, MI, MN, OH, VA, Washington DC, WI, and WV) Carrier) transactions for KY & IN, and DMERC transactions.

Administrative Services Only (ASO)
A contract between a group and a third party administrator to provide services such as actuarial, benefit plan design, claim processing, maintenance of enrollment needs, data collection and analysis, employee benefits communication, financial advice, and preparation of data for reports to governmental units for a self-funded plan.

American Dental Association (ADA)
A professional association of dentists committed to the public's oral health, ethics, science and professional advancement; leading a unified profession through initiatives in advocacy, education, research, and the development of standards. Maintains the hardcopy dental claim form and the associated claim submission specifications, and also maintains the Current Dental Terminology (CDT) code set. Has a formal consultative role under HIPAA.

American Medical Association (AMA)
A professional association of physicians committed to the standards, ethics, excellence in medical education and practice, and advocacy on behalf of the medical profession and patients. Serves as the secretariat of the National Uniform Claim Committee (NUCC) maintaining the Current Procedural Terminology (CPT) code set. Has a formal consultative role under HIPAA.

American National Standards Institute (ANSI)
A member of the International Organization for Standardization (ISO) that acts as the coordinating body for voluntary standards groups within the United States.

Anthem Common Edits
The edits performed consistently by the Application Front-End across all Anthem regions.

Anthem West
A regional entity of Anthem Blue Cross and Blue Shield, representing the states of Colorado and Nevada.

Anthem Gateway
The receptacle for all incoming electronic data files sent by providers to Anthem. Metaphorically, it can be viewed as a electronic bulk mail center for all incoming claims and other transactions that are appropriated sorted and routed to their intended recipient.

Anthem Consolidated Clearinghouse
The communications source that receives and distributes electronic transactions to and from external trading partners, houses a "mailbox" for each Trading Partner, and performs the following functions:

HIPAA Syntax Edits
Control Segment Balancing
Return of 997 Functional Acknowledgments
Transactions copied to Transaction Repository

Anthem Prescription Management (APM)
A pharmacy benefits management company that administers pharmacy programs in cooperation with leading health care plans.

Application Front-End Edits
Pre-Adjudication system EDI edits. (i.e. Check membership against system)

Arkansas Part A Shared System (APASS)
A national standard system maintained by Blue Cross Blue Shield of Arkansas and used to process Medicare Part A claims for Maine, New Hampshire and Vermont. Anthem Maine is the intermediary for providers from Maine, New Hampshire and Vermont who submit Medicare A claims.

Asynchronous (ASYNC)
A physical transfer of data to or from a device that occurs without a regular or predictable time relationship following the execution of an I/O request. Opposite from synchronous data transfer.

Automated Error Notification
A system process that automatically sends notification (via email or other predefined means) for all Critical Errors occurring at the Anthem Gateway /Clearinghouse.

Back-End Destination or Back-End Payers
The entity to which the Clearinghouse sends claims files to test or adjudicate. For example, Medicaid, Medicare A, or CIGNA is a back-end payer.

Back-End Processing
The application and systems programs that expedite the movement of transactions to their destination.

Batch
A group of records that is considered a single unit for processing.

Batch Mode
An environment in which EDI transactions are grouped together and processed en-masse. The sender sends multiple transactions to the receiver, either directly or through a clearinghouse, and does not remain connected while the receiver processes the transactions. Processing is normally performed on a nightly basis.

Billing Provider
An organization/billing entity or provider for which services are billed.

Billing Service
An organization that collects billing information and bills the appropriate party for the charges incurred by the patient.

Blocked Asynchronous Transmission (BLAST®)
A type of DOS-based communication software. As an asynchronous transmission, the length of time between transmitted characters may vary. The receiving modem must be signaled as to when the data bits of a character begin and when they end. (More information is available at the Internet site www.blast.com.)

Blue Cross and Blue Shield Association (BCBSA)
The trade association for the independent locally operated Blue Cross and Blue Shield Plans. Serves as the administrator for the Health Care Code Maintenance Committee and the Health Care Provider Taxonomy Committee. Maintains the Claim Adjustment Reason Codes (CAS) code set.

Business Partner
An entity involved directly or indirectly with Anthem. For example, software Vendors may act as business partners. They provide applications to our providers to send EDI transactions and may, or may not, directly exchange transactions with Anthem. (See Trading Partner).

Byte (B)
A unit of data (eight binary digits long) that most computers use to represent a character such as a letter, number, or typographic symbol.

Centers for Medicare and Medicaid Services
The Health and Human Services (HHS) agency responsible for Medicare and parts of Medicaid. Maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.
Effective July 14, 2001, it replaces the Health Care Financing Administration (HCFA).

Certificate
The insurance document issued to a covered individual in a group, setting forth the benefits of the plan.

Certificate of Coverage (COC)
A document provided to covered employees by the insurance carrier or managed care plan which outlines the benefits, covered services and principal provision of the group health plan provided under contract by the insurer or managed care organization.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

A Department of Defense regionally managed health-care program for active duty and retired members of the uniformed services and their families that combines military healthcare resources and networks of civilian healthcare professionals. Also known as "Tricare".

Claim

An itemized statement of healthcare services and their costs provided by a hospital, physician's office, or other provider facility. Submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

Claim Adjustment Group Code

A set of codes that identifies the general category of why a claim is adjusted.

CO – Contractual Obligations
CR – Corrections and Reversals
OA – Other Adjustments
PI – Payer Initiated Reductions
PR – Patient Responsibility

Claim Adjustment Reason Codes

A national code set indicating the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the current payment for it.

Clearinghouse

An entity that accepts electronic transactions from another organization, performs high-level edits, translates data from one format to another, and electronically routes the transaction to a receiving entity.

Code Set

Under HIPAA, any grouping used to encode data elements such as tables of terms, medical concepts, medical diagnostic codes, and medical procedure codes.

Composite

A subset of a segment consisting of multiple simple elements.

Control Segment

The process of verifying that the control segment counts within an interchange balance.

Control Segment Balancing

Verification that the control segment counts within the interchange balance.

Coordination of Benefits (COB)

A process for determining the respective financial responsibilities of two or more health plans to prevent double payment for services when a subscriber has coverage from two or more sources. EDI Coordination of Benefits is predicated upon using the two transactions – the 837 Health Care Claim and the 835 Health Care Payment Advice.

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986

A federal act which requires each group health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment.

Copayment

The amount paid by a member, flat dollar amount or percentage, towards the cost of a particular service.

Core Processing System (CPS)

Also known as the Target Processing System.

Crossover

The ability to forward claims to the secondary payer after the claim has been processed by the primary payer. Also, known as Coordination of Benefits.

Current Dental Terminology (CDT)

A dental code procedure code set maintained by the ADA that has been selected for use in the HIPAA transactions.

Current Procedural Terminology (CPT)

A health care industry's standard list of medical services and procedures performed by physicians and other providers nationwide. Each service and/or procedure is identified by a unique 5-digit code.

Data Content

Under ASC X12 standards, all the data elements and code sets inherent to a transaction and not related to the format of the transaction.

Data Element

Under ASC X12 standards, the basic unit of information in the EDI standards containing a set of values that represent a singular fact. Corresponds to a data field in data processing terminology, and may be single-character codes, literal descriptions, or numeric values.

Data Mapping

The process of matching one set of data elements or individual code values to their closest equivalents in another set of data elements or individual code values. Simply called "crosswalk".

Data Segment

Under ASC X12 standards, the data segment is used for transferring application information. Each data segment begins with a segment ID, contains related data elements and ends with a segment terminator. It is used primarily to convey user information. Corresponds to a record in data processing.

Data Transmission

The sending of data from one place to another for processing.

Data Validation Edits

HIPAA Level 1 and 2 edits, checking file format, syntax and code tables

Deductible

The amount which members are required to pay toward the cost of their care before Anthem Blue Cross and Blue Shield will begin payment for services.

Delimiter

A character, such as an asterisk (*), used to separate two data elements or to terminate a segment; a common element separator.

Department of Health and Human Services (DHHS)

The Federal Government Department that has overall responsibility for implementing HIPAA.

Dependent

In the hierarchical loop coding, the dependent code indicates the use of the patient hierarchical loop (Loop 2000C).

Designated Code Set

A medical code set or an administrative code set that Department of Health and Human Services has designated for use in one or more of the HIPAA standards.

Destination Payer

The destination payer is the payer who is specified in the Subscriber/Payer loop (Loop ID-2010BB).

Diagnosis Related Grouping (DRG)

A statistical system of classifying any inpatient stay into groups for the purposes of payment. This is the form of reimbursement that the HCFA uses to pay hospitals for Medicare recipients.

Direct Data Entry (DDE)

A method of simply manually typing information from a claim onto a form on a screen before processing.

Document Control Number (DCN)

The unique identifier assigned to be imaged documents to facilitate image retrieval.

Duplicate Submission

A transmission of an electronic claims file that exactly matches a file sent in an earlier transmission with the same Submitter ID.

E-Commerce (EC)

Integration of electronic mail, EFT, EDI, and similar techniques into a comprehensive, electronic-based system encompassing business functions such as procurement, payment, supply management, transportation, and facility operations.

Electronic Data Interchange (EDI)

The computer-application-to-computer-application exchange of business information in a standard electronic format. Translation software aids in exchange by converting data extracted from the application database into standard EDI format for transmission to one or more trading partners.

Electronic Envelope

Electronic information that binds together a set of transmitted documents being sent from one sender to one receiver. Also, controls and tracks interchanges. One interchange may contain many transaction sets grouped into functional groups. The interchange includes control segments such as the ISA, IEA, GS, and GE.

Electronic Funds Transfer (EFT)

A system of transferring money from one bank account directly to another without any paper money changing hands through the Automated Clearing House (ACH) network, the secure transfer system that connects all U.S. financial institutions. For payments, funds are transferred electronically from one bank account to the billing company's bank, usually less than a day after the scheduled payment date.

E-Mail (EM)

The exchange of computer-stored messages, text and non-text files, such as graphic images and sound files.

Employer Identification Number (EIN)

Also known as the Federal Tax Number.

Encryption

Process of transforming clear text (data in its original form) into cipher text (encryption output of a cryptographic algorithm) for security or privacy.

Exclusions

Causes and conditions listed in the policy or contract which are not covered and for which no benefits are payable.

Explanation of Benefits (EOB) or Medicare Benefits (EOMB)

A billing summary from an insurance company or Medicare that is mailed to a member or covered insured detailing the charges for services rendered, and which portions are paid by insurance and the amount the patient must pay.

Facsimile (FAX)

A copy or image of an electronic transaction.

Fast-Batch Mode

Differs from a batch mode environment in that processing of these claims normally occurs within a 4-hour period of receipt.

FastEMC®

HIPAA editing software supported and maintained by fP technologies, Inc of Indianapolis, IN.

Federal Employee Health Benefits Program (FEHBP)

The program that provides health benefits to federal employees.

Federal Tax Number

The number assigned to the provider by the Federal government for tax reporting purposes. Also known as Tax Identification Number (TIN) or Employer Identification Number (EIN).

Fee for Service (FFS)

A benefit payment system in which an insurer reimburses the group member or pays the health care provider directly for each covered health expense after the service is performed.

File Transfer Protocol (FTP)

A standard Internet protocol commonly used to exchange files such as Web page files between computers on the Internet. It is also commonly used to download programs and other files to your computer from other servers.

Flat File

A file containing a series of fixed-length records that have no structured interrelationship. Used to describe a textual document from which all word processing or other structure characters or markup have been removed. For example, many users would call a Microsoft Word document that has been saved as "text only" a "flat file."

Format

Pre-established layout of those data elements that provide or control the enveloping or hierarchical structure of an EDI transaction, or assist in identifying data content of a transaction. For example, the ANSI V4010 is the format mandated by HIPAA.

Formatting Errors

Under HIPAA, irregularities in those data elements that provide or control the enveloping or hierarchical structure of an EDI transaction, or assist in identifying data content of a transaction, may be reported as errors.

Frame Relay

A telecommunication service designed for cost-efficient data transmission for intermittent traffic between local area networks (LANs) and between end-points in a wide area network (WAN). Puts data in a variable-size unit called a frame and leaves any necessary error correction (retransmission of data) up to the end-points, which speeds up overall data transmission.

Front-End Processing

The production of an Activity Report to inform the sender if the file type sent was delivered.

Functional Group

Under ASC X12 standards, a formal structure that defines a group of similar transaction sets and identifies LOB/Application information (i.e., Medicare, BC, Commercial) Anthem intends to route transactions based on the functional group.

Functional Group Header (GS)

A formal structure that identifies the group of transaction sets that are included within the functional group such as the functional control group, sender, receiver, date, time, group control number and version/release/industry code for the transaction sets.

Functional Group Control Segment (GS/GE Control Segment)

Under ASC X12 standards, a formal structure that is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). Identifies the start of a functional group, defines the group of transactions that may be included and is used to identify the sending and receiving unit of the transmission. May have multiple transaction sets within a Functional Group and multiple Functional Groups within an Interchange.

Functional Group Trailer (GE) –

A formal structure that indicates the end of the functional group and provides control information.

get

FTP command to receive a file from the host system, may also use mget to receive multiple files.

Group Health Plan

An employee welfare benefit plan, including insured and self-insured plans, to the extent that the plan provides medical care including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise.

Hardware

The physical aspect of computers, telecommunications, and other information technology devices. Opposite of 'software'.

Health Care Clearing House

Allows providers to transmit claims for multiple payers in a single transmission. These claims are validated through front-end edits and forwarded to payers for processing. A clearinghouse may offer:

24 hour a day, seven day a week availability for convenient claims submission.

Claims may be sent for Anthem Blue Cross and Blue Shield, other Blue Cross Plans, Medicare Part A, and a large number of commercial payers.

Acceptance of standard claim formats, including UB92 version 6.0 which the Clearinghouse reformats to meet payer requirements.

Submission reports, which are available within 24 hours after transmission, indicate whether claims have been accepted and routed to the appropriate payer or if they require corrections in order to be processed.

Enhanced editing to ensure that the cleanest possible claims are submitted to payers.

Technical support available from the E-Commerce Support Services staff.

Health Care Financing Administration (HCFA)

The former name of the federal agency within the Department of Health and Human Services (DHHS) established to administer the Medicare, Medicaid, and State Children's Health Insurance Programs. Agency is now known as the Centers for Medicare & Medicaid Services (CMS).

Health Care Financing Administration Common Procedural Coding System Codes (HCPCS)

Information in the Remittance Advice transaction is generated by the payer's adjudication system to indicate the claim has been paid. However in a coordination of benefits (COB) situation where the provider is sending an 837 to a secondary payer, information from the 835 may be include in the secondary 837.

Health Information

A telecommunication service designed for cost-efficient data transmission for intermittent traffic between local area networks (LANs) and between end-points in a wide area network (WAN). Puts data in a variable-size unit called a frame and leaves any necessary error correction (retransmission of data) up to the end-points, which speeds up overall data transmission.

Health Insurance Portability and Accounting Act (HIPAA)

HIPAA of 1996 (Public Law 104-191) includes provisions for administrative simplification that require the Secretary of the Department of Health and Human Services to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard. Regulations address key areas including Transaction and code sets, Standard identifiers, Security and electronic signatures, and Privacy standards. With the issue of Privacy and Security, regulations address key areas of consumer control, boundaries, accountability, public responsibility, and security.

Health Maintenance Organization (HMO)

A licensed health plan responsible for the cost, quality, and delivery of a broad range of comprehensive health services. With an increasing emphasis on wellness and prevention, Primary Care Physicians serve as the entry point to receive health care. Reimbursement methods for network providers may include the introduction of financial risk arrangements, which involve shared cost control responsibility between providers and payers.

Hierarchical (HL) Structure/Segment

Under ASC X12 standards, used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber.

HIPAA Compliant

Describes data content and structure that abides by HIPAA implementation guidelines.

HIPAA Implementation Guide

A government publication describing the HIPAA compliance standards and used as a primary reference by those implementing the associated transactions.

Immediate Sender

A Trading Partner who directly submits EDI transactions to Anthem's Gateway. The immediate sender will always receive the Activity Report and the 997 Functional Acknowledgment.

Implementation Guide (IG)

A document explaining the proper use of a standard for a specific business purpose.

Inbound

Refers to either a trading partner or transaction. Anthem exchanges electronic transactions to inbound Trading Partner through the Front-End Gateway. An inbound transaction is one that is delivered or received through the Front-End Gateway.

Individually Identifiable Health Information (IIHI)

A subset of health information, including demographic information collected from an individual, and:
Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
Identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

In Source Data Entry (ISDE)

Using In Source Data Entry (ISDE), the claim is imaged and then manually keyed into system.

Indemnity

A traditional insurance program providing benefits in a predetermined amount for covered services. Traditionally, payment is made on a fee-for-service basis.

Integrated Delivery System (IDS)

A system of health care providers organized to span a broad range of health care services.

Interchange

The envelope and/or complete batch of data that is transmitted between Trading Partners.

Interchange Acknowledgment (TA1)

A response indicating the failure of an interchange envelope and its contents.

Interchange Control Header (ISA)

The beginning, outermost envelope of the interchange that contains authorization and security information, and identifies the sender, receiver, date, time, and interchange control number.

Interchange Control Structure (ISA/IEA Segment)

Under ASC X12 standards, this includes strict format rules to ensure the integrity and maintain the efficiency of the interchange. Delineated by the Interchange header (ISA segment) and trailer (EIA segment), data elements such as authorization and security information, sender and receiver information and test or production mode indicator are included.

Interchange Control Trailer (IEA)

The IEA segment is the ending, outermost envelope of the interchange that indicates the number of functional groups included with the interchange and the interchange control **number.**

International Classification of Diseases (ICD)

Designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics.

International Classification of Diseases Clinical Modification (ICD-9-CM)

Used to code and classify morbidity data from the inpatient and outpatient records, physician offices, and most National Center for Health Statistics (NCHS) surveys.
Includes a 1) tabular, numerical list of disease code numbers, 2) alphabetical index to the disease entries, and 3) alphabetic index and tabular list of surgical, diagnostic, and therapeutic procedures.

International Organization of Standardization (ISO)

Established as a non-governmental organization in 1947, this worldwide federation of national standards bodies represents more than 140 countries, one from each country. Its mission is to promote the development of standardization and related activities in the world with a view to facilitating the international exchange of goods and services, and to developing cooperation in the spheres of intellectual, scientific, technological and economic activity.

Job Control Language (JCL)

A header file attached to incoming data that provides a list of instructions for the Mainframe.

Kermit

A file transfer protocol first developed at Columbia University in New York City in 1981 for the specific purpose of transferring text and binary files without errors between diverse types of computers over potentially hostile

communication links. It consists of a suite of communications software programs from the Kermit Project at Columbia University. The Kermit protocol and software are named after Kermit the Frog, star of the television series, The Muppet Show. The name Kermit is used by permission of Henson Associates, Inc.

Line of Business (LOB) [elaborate as we're using professional, institutional, and dental also…]

Any group of insurance companies or intermediaries that is the destination of claims submitted for reimbursement. Each line of business is designated by a source of pay code.

Logical File

A set of records containing formatted data which makes up an EDI transaction. For example, the UB92 claim transaction is composed of a set of records beginning with record type 01 and ending with record type 99.

Loop

The largest named unit of information in a transaction set. A loop contains logically related segments in a defined sequence in order to group related information together. Loops may repeat up to a specified number of times. They may be optional, situational or mandatory based on the usage of the first segment of that loop.

Mailbox/Mailboxing

Place where an EDI transmission is stored for pickup or delivery within a third party service provider's system. Specifically, a mailbox is setup in the Gateway for each Trading Partner and is used to receive and distribute electronic transactions to and from the external Trading Partners.

Mainframe

A very large and expensive computer supporting hundreds, or even thousands, of users simultaneously.

Managed Care Organization (MCO)

A generic term applied to a managed care plan.

Managed Indemnity (MI)

Uses simple pre-certification of elective admissions and case management of catastrophic cases, superimposed on a traditional indemnity insurance plan.

Mapping

The translation from an electronic standard format to a company's proprietary or internal format.

Medicaid

A jointly-funded, Federal-State health insurance program for certain low-income and needy people that covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.

Medical Carrier

An entity contracted by CMS (Centers for Medicare and Medicaid services) to process Medicare Part B (Professional) and/or DMERC transactions.

Medicare Intermediary

An entity contracted by CMS (Centers for Medicare and Medicaid services) to process Medicare Part A (Institutional) transactions. Associated Hospital Services Is the intermediary for CT, ME, NH, MA, RI and VT

Medicare Secondary Payer (MSP)

A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Medigap or Medicare Supplement

A private medical expense insurance policy that provides reimbursement for out-of-pocket expenses, such as deductibles and coinsurance payments, or benefits for some medical expenses specifically excluded from Medicare coverage.

Medicare Part A

The Medicare component that provides basic hospital insurance to cover the costs of inpatient hospital services, confinement in nursing facilities or other extended care facilities after hospitalization, home care services following hospitalization, and hospice care.

Medicare Part B

The Medicare component that provides benefits to cover the costs of physicians' professional services, whether the services are provided in a hospital, a physician's office, an extended-care facility, a nursing home, or an insured's home.

Mercator (Suite)

A software vendor that offers a suite of products to accommodate reformatting data files, establishing and maintaining Trading Partner relationships and a scheduler to accommodate execution of the defined processes.

MODEM

A device that modulates signals transmitted over communications circuits used to convert digital signals into analog signals and vice-versa.

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. Used in reporting prescription drugs in pharmacy transactions and some claims by health care professionals. NDC are assigned when drugs are approved or packaged and the codes may be found on the drug packages themselves. The National Drug Code serves as a universal product identifier for human drugs.

National Standard Format (NSF)

A 320-byte flat file record format used to submit professional claims. 192-byte flat file format used to submit institutional claims. These formats are pre-HIPAA and move to 837P ANSI file for professional and 837I for institutional as of October 16, 2003.

National Uniform Billing Committee (NUBC)

An organization, chaired and hosted by the American Hospital Association (AHA), and includes the participation of all the major national provider and payer organizations. Formed to develop a single billing form and standard data set that could be used nationwide by institutional providers and payers for handling health care claims. Has a formal consultative role under HIPAA for all transactions affecting institutional health care services.

National Uniform Billing Committee UB92 Codes

A standard data set that could be used nationwide by institutional providers and payers for handling health care claims. This built-in flexibility of the data set is intended to promote the greatest use of the data set and to eliminate the need for attachments to the billing form.

National Uniform Claim Committee (NUCC)

Chaired by the American Medical Association with the Health Care Financing Administration (HCFA) as a critical partner, this group was created to develop a standardized data set for use by the non-Institutional health care community to transmit claim and encounter information to and from all third-party payers.

Network Data Mover (NDM)

A direct electronic method of delivering Competitive Local Exchange Carrier (CLEC) and Reseller usage data files and Reseller bills, and transmitting CLEC Access Service Requests (ASR). Available in several platforms including NDM-MVS for mainframe and NDM-PC for personal computers. Known in Verizon as Connect: Direct.

Optical Character Recognition (OCR)

Photoscanning of printed or written text character-by-character, analysis of the scanned-in image, and then translation of the character image into character codes commonly used in data processing. For Anthem, the paper claim is imaged, converted to text using software, and sent to the clearinghouse.

Original Sender

Any entity that relies on another entity (Clearinghouse, billing service) to submit their EDI claims to Anthem's Gateway. Original Senders may opt to directly receive Claim Payment and Remittance Advice directly from the Gateway.

Organized Health Care Arrangement (OHCA)

A clinically integrated care setting in which individuals typically receive health care from more than one health care provider; an organized system of health care in which more than one covered entity participates, and in which the participating covered entities hold themselves out to the public as participating in a joint arrangement, and they participate jointly in utilization review, quality assessment and improvement activities, or payment activities; and certain relationships between a group health plan and HMOs, health insurers and/or other group health plans.

For example, covered entities participating in the OHCA can share personal health information (PHI) with each other for treatment, payment or health care operations purposes. So when the patient is in the hospital, all the treatment providers - the hospital and all physicians - in the OHCA can rely on one consent and one privacy notice, and can share PHI.

Outbound

Outbound may refer to either a Trading Partner or transaction. Anthem exchanges electronic transactions to outbound Trading Partner through the Back-End Gateway. An outbound transaction is one that is delivered or received through the Back-End Gateway.

Paired Transactions

Transactions that are directly related to one another. Normally will consist of a request and a response. Example: 276/277 Claim Status Request and Response.

Patient

The term "patient" is intended to convey the case where the Patient loop (Loop ID-2000C) is used. In that case, the patient is not the same person as the subscriber, and the patient is a person (e.g., spouse, children, others) who is covered by the subscriber's insurance plan. However, it also happens that the patient is sometimes the

same person as the subscriber. In that case, all information about the patient/subscriber is carried in the **Subscriber loop (Loop ID-2000B).**

Payer

Insurance companies, fiscal intermediaries, carriers or government agencies responsible for the payment of health care claims.

Payer ID

The unique number for a particular payer. Also known as the Payer Organization ID.

Personal Computer (PC)

A computer designed for use by one person at a time. Beginning in the late 1980s, technology advances made it feasible to build a small computer that an individual could own and use. Also, the term "PC" is also commonly used to describe an "IBM-compatible" personal computer.

Pharmacy and Therapeutics (P&T)

An organized panel of physicians from varying practice specialties, who function as an advisory panel to the plan regarding the safe and effective use of prescription medications. Often comprises the official organizational line of communication between the medical and pharmacy components of the health plan. A major function of such a committee is to develop, manage and administer a drug formulary.

Physical File

May contain multiple logical files. The physical file ends with a hex end-of-file marker.

Physical Medicine and Rehabilitation (PM&R)

A multidisciplinary approach, including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker and psychologist, provided on an inpatient basis.

Point of Service (POS)

A clinically integrated care setting in which individuals typically receive health care from more than one health care provider; an organized system of health care in which more than one covered entity participates, and in which the participating covered entities hold themselves out to the public as participating in a joint arrangement, and they participate jointly in utilization review, quality assessment and improvement activities, or payment activities; and certain relationships between a group health plan and HMOs, health insurers and/or other group health plans.

For example, covered entities participating in the OHCA can share personal health information (PHI) with each other for treatment, payment or health care operations purposes. So when the patient is in the hospital, all the treatment providers - the hospital and all physicians - in the OHCA can rely on one consent and one privacy notice, and can share PHI.

Point-to-Point Protocol (PPP)

A method of connecting a computer to the Internet. For example, your Internet server provider may provide you with a PPP connection so that the provider's server can respond to your requests, pass them on to the Internet, and forward your requested Internet responses back to you.

PPP uses the Internet protocol (IP) (and is designed to handle others). It packages your computer's TCP/IP packets and forwards them to the server where they can actually be put on the Internet. PPP is more stable than the older Serial Line Internet Protocol (SLIP) and provides error-checking features. It can handle synchronous as well as asynchronous communication.

Preferred Provider Organization (PPO)

An entity through which employer health benefit plans and health insurance carriers contract to purchase health care services from a network of participating providers. Typically, participating providers agree to abide by utilization management practices and agree to accept the PPO's reimbursement structure and payment levels. Members may be permitted to use non-PPO providers (out of network), with higher co-pays or deductibles.

Primary Care Physician (PCP) [Which definition is easier?]

A physician or other medical professional (family practice, internal medicine, pediatrics) who manages and focuses on a patient's overall health by providing basic medical care and, when appropriate, referring to other network providers. He or she serves as the patient's first contact with a plan's healthcare system.

Proprietary Format

A format/transaction that does not comply with a standard. For example, proprietary drugs are used, produced, or marketed under exclusive legal right of the maker and protected by secrecy, patent, or copyright against free competition as to name, product, composition, or process of manufacture

Protected Health Information (PHI)

Individually identifiable health information in any form (including electronic media, paper, and oral.). Under HIPAA privacy rules, PHI can only be disclosed for reasons of payment, treatment or healthcare options.

Protocol

A formal set of conventions governing the format and relative timing of message exchange between two communication processes

Provider

A person, organization, or institution that provides services related to medical treatment. Specific types of providers are identified in the implementation guide (e.g. billing provider, referring provider).

Public Key Infrastructure (PKI)

An identity verification model that uses digital certificates, trusted certificate authorities and public/private encryption keys to authenticate communications from a specific sender to a specific recipient.

put

FTP command used to send a file, may also use mput to send multiple files.

Real Time

Transactions that generally require an immediate response. In a real time mode, the sender sends a request transaction to the receiver, either directly or through a switch (clearinghouse). The sender remains connected while the receiver processes the transaction and returns a response transaction to the original sender. Typically, response times range from a few seconds to about thirty seconds, and should not exceed one minute. When in real time mode, the receiver must send a response of the response transaction, a 997 Functional Acknowledgment, or a TA1 segment. Generally, 837 claims are processed in a batch mode with the possible exception of preadjudication or predetermination of benefits situations (determined by trading partner agreements).

Record

A series of related fields of information in a data file.

Region

Anthem is comprised of the following regions:

East – Connecticut, New Hampshire, Maine.
SouthEast – Virginia
Midwest – Indiana, Kentucky, and Ohio
West – Colorado and Nevada

Regional Processing Systems

Processing Systems located in each region:

East – ACES, Nasco, FEP, DIS
Midwest – Facets, Nasco, FEP
West – AMISYS, Nasco, FEP, HMS

Relative Value Unit (RVU)

A scale that determines the amount of resources a physician utilizes to provide a service or procedure compared to resources needed to provide a different service or procedure.

Remittance Advice (RA)

Refers to the 835 Health Care Payment Advice generated by the payer's adjudication system.

Rendering Provider

Also, known as Performing Provider. Attending or consulting provider that has rendered the services being billed.

Response Report file (RSP)

Refers to the 997 Functional Acknowledgment, the 864 Response Report, Claim Detail.

Routing

The process of identifying a transaction for delivery to its intended destination, Routing occurs at the clearinghouse level and will be performed at the highest level possible (ISA/GS segments). Transactions are staged for pickup by the appropriate System's Application Front-End.

Secondary Payer

An insurance policy, plan, or program that pays second or thereafter on a claim for medical care.

Segment

A defined sequence of logically related data elements.

Skilled Nursing Facility (SNF)

A health facility with organized medical staff and continuous professional nursing services to provide inpatient care for convalescent patients whose conditions do not merit hospital care.

Software

A general term for the various kinds of programs, rules and associated documentation used to operate computers and related devices. Opposite of 'hardware'.

State Uniform Billing Committee (SUBC)

A state-specific affiliate of the National Uniform Billing Committee (NUBC). Chaired and hosted by the American Hospital Association (AHA), this organization 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.

Store and Forward

A network delivery method that does not use real-time communication. Text or image data are received by the network and held for later delivery. "Later" can be less than a minute or several hours, depending on the type of communications and network delivery protocols. Specifically, the process occurs in the Anthem Gateway, transactions are received in a mailbox (stored) and then passed (forwarded) to the clearinghouse.

Strategic National Implementation Process (SNIP)

A collaborative healthcare industry-wide process resulting in the implementation of standards and furthering the development and implementation of future standards.

Submitter

The entity sending claims electronically.

Subscriber

The individual whose name is listed in the health insurance policy. Other synonymous terms include "member" and/or "insured." In some cases, the subscriber is the patient.

Summary Report file (SUM)

Refers to the 864 Response Report, Claim Detail.

Syntax

The set of rules, conventions and file structure (order and arrangement of parts) that must be followed to record valid information for a specific purpose. HIPAA specific syntax is described in the HIPAA Implementation Guides.

Syntax Edits

Validation of EDI transactions for compliance with syntax and grammar (i.e., structure, format, codes, data types, lengths, required segments, required data elements) performed by the clearinghouse.

Syntax Errors

Errors detected as a result of the Syntax Edits. Under HIPAA, syntax errors will be returned on a 997 Functional Acknowledgment.

Tax Identification Number (TIN)

See Federal Tax Number.

Third Party Administrator (TPA)

A company that provides administrative services to managed care organizations or self-funded health plans but that does not have the financial responsibility for paying benefits.

Trading Partner

Refers to parties engaged in the exchange of business data through electronic means. (See Business Partner)

External: A non-Anthem entity that electronically exchanges data with Anthem (i.e., providers, pharmacies, labs, other payers, clearinghouses, employers, billing services and members).

Internal: A Trading Partner that is a part of Anthem. Includes adjudication, payment or processing systems.

Trading Partner Agreement

Clarifies and simplifies implementation for providers and vendors.

Trading Partner Profile Database

Defines information about all entities exchanging EDI transactions with the Anthem Clearinghouse. This includes transactions, delivery, format, imaging, and transaction history information.

Transaction History Repository

Storage of all transactions received from a Trading Partner that have been delivered to another Trading Partner.

Transaction Repository Database

Storage of all transactions received from a Trading Partner but not yet delivered to another Trading Partner.

Transaction Level Editing

The Strategic National Implementation Process (SNIP) White Paper on Front End Edits recommends 3 levels of reporting:

Transaction Format (X12) Syntax Checking

HIPAA Implementation Guide Compliance Checking

Since error reporting standards have not been specified by the Secretary of the U. S. Department of Health and Human Services and Anthem has a technically diverse Trading Partner population, Anthem uses the 864 for Error Reports with an option of an 824 for those Trading Partners who request it.

Application (or Adjudication) System Edits

Transaction Set

Under ASC X12 standards, a formal structure that defines, in the standard syntax, information of business significance (i.e., health care claim, premium payment) and is the smallest meaningful set of information

exchanged between trading partners. Consists of a header segment, one or more path segments in a specified order, and a trailer segment.

Transaction Set Control Segment (ST/SE)

Under ASC X12 standards, a formal structure that is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment).

Transaction Set Header (ST)

Identifies the beginning of a transaction set. Used to convey business data (i.e., ST01, ST02)

Transaction Set Trailer (SE)

Identifies the end of the transaction set.

Transaction Type

Under HIPAA, this is the exchange of information between two parties to administer financial or administrative activities related to healthcare, The HIPAA mandate, ANSI X12 V4010 transaction set includes:

270/271 Health Care Eligibility Benefit Inquiry and Response

Paired transaction comprised of requesting (inquiring) information and then responding with coverage, eligibility, and benefit information

276/277 Health Care Claim Status Request and Response

Paired transaction comprised of requesting the status of a claim and responding with the information regarding the specified claim(s). Requestors include hospitals, nursing homes, laboratories, physicians, dentists, allied professional groups, employers, and supplemental (i.e., other than primary payer) health care claims adjudication processors. Responders include payers, who may be insurance companies, third party administrators, service corporations, plan purchasers, and any other entity that processes health care claims. Other business partners include billing services, consulting services, vendors of systems, software and EDI translators, and EDI network intermediaries, Value-Added Networks, and telecommunications services.

278 Health Care Services Review – Request for Review and Response

Purpose to request reviews (specialty care, treatment, admission) and those responding to the requests with the information

820 Payroll Deducted and Other Group Premium Payment for Insurance Products

Purpose of reporting payroll deducted and other group premiums – submitters sending premium payments to an insurance company, health care organization or government agency

834 Benefit Enrollment and Maintenance

Used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer

835 Health Care Claim Payment / Remittance Advice

Purpose of sending and/or receiving electronic remittance advice. Receivers include hospitals, nursing homes, laboratories, physicians, dentists, and allied professional groups. Senders include insurance companies, third party administrators, service corporations, state and federal agencies and their contractors, plan purchasers, and any other entities that process health care reimbursements. Other business partners include Depository Financial Institutions, billing services, consulting services, vendors of systems, software and EDI translators, EDI network intermediaries, value-added networks, and telecommunication services.

837 Health Care Claim: Professional, Institutional, or Dental Claims

Purpose of achieving a totally electronic data interchange health encounter / claims processing and payment environment

864 Text Message

Provides electronic communication – moves messages, contracts, explanations, and other one-time communications.

997 Functional Acknowledgment

Purpose of indicating receipt and syntactical acceptability of data transmitted according to the ASC X12 standards.

Translation

The act of converting documents from one format to another, particularly the conversion between internal flat file application formats and standardized formats.

Translator (EDI Translator)

A software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI data file into an EDI format for transmission.

Transmission

A communication session during which one or more transactions is transmitted.

Transmission Intermediary

Any entity that handles the transaction between the provider (originator of the claim/encounter transmission) and the destination payer. The term "intermediary" is not used to convey a specific Medicare contractor type.

UNIX

A popular multi-user, multi-tasking operating system developed at Bell Labs in the early 1970s. Created by just a handful of programmers, UNIX was designed to be a small, flexible system used exclusively by programmers. Although it has matured considerably over the years, UNIX still betrays its origins by its cryptic command names and its general lack of user-friendliness. Due to its portability, flexibility, and power, UNIX has become the leading operating system for workstations.

UNIX-to-UNIX Copy Protocol (UUCP)

A set of UNIX programs for copying (sending) files between different UNIX systems and for sending commands to be executed on another system. The main UUCP commands (each supported by a UUCP program) are:

uucp, which requests the copying of a specific file to another specified system
uux, which sends a UNIX command to another system where it is queued for execution
uucico, which runs on a UNIX system as the program that carries out the copying and initiates execution of the commands that have been sent. Typically, this program is run at various times of day; meanwhile, the copy (uucp) and command (uux) requests are queued until the uucico program is run.
uuxqt, which executes the commands sent by uux, usually after being started by the uucico program
The uucico programs are the programs that actually communicate across a network. There are several network protocols (variations on packet size and error-checking) that can be used by uucico programs, depending on the kinds of carrier networks being used.

V.42

An error-detection standard for high-speed modems that also can be used with digital telephone networks.

Workgroup of Electronic Data Exchange (WEDI)

A group of health industry executives that believed that the electronic data interchange (EDI) for health care transactions offered significant potential in reducing health care administrative costs. Their work resulted in federally adopted standards for electronic transactions, codes data privacy and security.

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.

Xmodem

Developed by Ward Christensen in 1977, a protocol for transferring files during direct dial-up communications. Xmodem has basic error checking to ensure that information is not lost nor corrupted during transfer; it sends data in 128-byte blocks. Xmodem has undergone a couple of enhancements: Xmodem CRC uses a more reliable error-correction scheme, and Xmodem-1K transfers data faster by sending it in 1,024-byte blocks.

Ymodem

An asynchronous communications protocol designed by Chuck Forsberg for transferring files during direct dial-up communications. Building on the earlier Xmodem protocol, Ymodem sends data in 1,024-byte blocks and is consequently faster than Xmodem. However, it does not work well on noisy phone lines, unlike its successor, Zmodem. Ymodem has undergone a few enhancements: Ymodem-Batch can send several files in one session; Ymodem-G drops software error correction, which accelerates the process by leaving hardware-based error correction in modems.

Zmodem

Intended to supersede Xmodem and Ymodem, a transfer protocol for sending and receiving files using dial-up connections with enhanced speed and error checking. Zmodem can resume a file transfer after a break in communications. Zmodem protocol should be available in both your communications software and any BBS where you dial.