Term	Definition
270	Health Care Eligibility Benefit Inquiry
271	Health Care Eligibility Benefit Response
276	Health Care Claims Status Request
277	Health Care Claims Status Response
278	Health Care Services Request for Review and Response (Prior Authorization)
835	Health Care Claims Payment / Advice
837	Health Care Claim
837D	Dental Health Care Claim
837I	Institutional Health Care Claim
837P	Professional Health Care Claim
Accepted	Terminology referring to paper, electronic, and system generated claims that are accepted into the EDS-CMS system for processing
ADA	American Dental Association (develops codes for dental procedures)
Adjustment Request	Provider generated request to make a change on a previously submitted claim.
AFC	Adult Foster Care
ANSI	American National Standards Institute, an organization that accredits various standards setting committees and monitors their compliance.
Applied Income	The portion of a client's income to be applied towards the cost of his/her long term care services per Medicaid rules.
Atypical	Services that are deemed non-medical in nature or those services determined by DHS/MHMR to not have an appropriate National Procedure/Revenue Code.
Batch	Scheduled processing of one or more logical documents grouped together as a file. A group of transactions for one provider within a transmission.
Batch Number	The number assigned to an individual batch within a transmission to ECMS.
BBS	Bulletin Board System
Bill Code	Code depicting a service performed by the provider.

Term	Definition
Bill Code Crosswalk	A table that translates the information used in filing a claim now to information necessary to complete the claim after HIPAA implementation.
Billing Cycle	The period of time from the point of submitting a request for payment to the point of receipt of payment.
Budget Number	The budget a claim will bill against. The second modifier field will be used to denote which budget is being used.
CBA	Community-based Alternatives Waiver Program
CCAD	Community Care for the Aged and Disabled Program
Claim	An original/initial request for payment of services for a single client that consists of one or more line item. A claim can be submitted on paper or electronically.
Claim Filing Indicator Code	Code identifying the type of claim or expected adjudication process. Found on the 835 and 837 transactions.
Claim Frequency Code	Code specifying the frequency of the claim. Found on the 835 and 837 transactions.
Claim History	A record of all accepted claims submitted to CMS
Claim Status Codes	A national administrative code set that identifies the status of health care claims. This code set is used in the X12 277 Claim Status Notification transaction.
Claim Status Inquiry (CSI)	A transaction (276), requesting information on the status of a claim previously submitted to CMS for processing.
Claim Type	A code that identifies the category a claim falls within.
Claims Management System	Integrated, generic term for the computer platforms and applications that work together to support long-term care programs for Texas.
CLASS	Community Living Assistance and Support Services Program
Client	CMS term for the health care consumer eligible for long term care services thru TDHS or TDMHMR.
Client Control Number (Patient Account	User defined number submitted on a claim

Term	Definition
Number)	to identify the health care consumer .
Client Number	The number assigned to an individual by TDHS. If the client becomes Medicaid eligible, the client number becomes their Medicaid number.
CMS	Acronym for the TDHS/TDMHMR claims management system.
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.
Compliance Date	Under HIPAA, this is the date which a covered entity must comply with a standard, an implementation specification, or a modification. For EDI it is October 16, 2003.
Consumer Managed Personal Attendant Services (CMPAS)	Financial intermediary services provided to eligible clients who supervise or have some who can supervise their attendant or have Clients are responsible for nterviewing, selecting, training, supervising, and releasing their attendants.
Co-Payment	The assessed amount or percentage of the cost of services that the client or co-insurance is responsible for paying.
Covered Entity	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.
CPT-4	Physician Current Procedural Terminology (for most acute care medical services)
CWP	Consolidated Waiver Program
DAHS	Day Activity and Health Services
Data Content	Under HIPAA, this is all of the data elements and code sets inherent to a transaction.
DBMD	Deaf-Blind with Multiple Disabilities Program
Deny	Terminology referring to paper, electronic and system generated claims that are accepted into the EDS-CMS system for processing but are subsequently denied

Term	Definition
	for claims payment.
DHS (TDHS)	Texas Department of Human Services
Diagnosis Code	An ICD-9 diagnosis code identifying a diagnosed medical condition.
DLN	Document Locator Number
DME	Durable Medical Equipment
Document Locator Number (DLN)	Number assigned to identify each warrant request.
EBX	EDS Clearinghouse for Electronic Transmissions
EDI	Acronym for Electronic Data Interchange
Edits	Checkpoints for claim validity and long term care business rules in claims processing. Four types of edits are: acceptance, local, LTC policy and validity.
EDS	Electronic Data Systems
Electronic Data Interchange	Electronic exchange of formatted data
Emergency Dental Services	Program that provides dental care to residents in nursing facilities
Emergency Response Systems	Services provided thru electronic monitoring systems used to convey signals for assistance.
EOB	Explanation of Benefits
ERS	Emergency Response Systems
ESI	Eligibility Services Incorporated
Expedited Claims	Claims submitted for rapid payment for services.
Explanation of Benefits	Explanation of the disposition of a provider claim.
Explanation of Benefits	An explanation of the payment or denial of a provider claim.
Finalized Claim	A claim that has completed processing thru CMS resulting in payment or denial of payment.
Fund Code	Code that identifies the source of funds to be paid to a provider for a particular service
Graphical User Interface (GUI)	A graphical vs purely textual user interface of a computer. It provides a “picture-oriented” way to interact with technology.
HCPCS	Health Care Common Procedural Coding System is a medical code set that identifies health care procedures, equipment and supplies for claim submission purposes.

Term	Definition
Health Care Claim (837)	Claim submitted by a provider requesting payment for services provided to the health care consumer.
Health Care Clearinghouse	Under HIPAA, an entity that processes or translates received from another entity in non-standard format into HIPAA compliant format.
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 used 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 and employers; and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. (Public Law 104-191)
HIPAA	Health Insurance Portability and Accountability Act of 1996.
ICN	Internal Control Number
Interactive	Real time processing of a transaction taking place while the submitter remains directly or indirectly connected to the processing computer.
Interactive Submission	Submission of a single transaction to the Tandem MMIS.
Interface	The point at which two systems connect to pass data.
Internal Control Number	A number assigned by EDS-CMS to uniquely identify a claim.
Item Code	Defines the item authorized for purchase or the service authorized for payment. The item code will not be used for services or purchases made on or after 10/16/03.
Line Item	A claim line item consists of services performed for a client within a specified period of time.

Term	Definition
Line Item Control Number	Identifier assigned by the submitter to the respective line item.
Local Code	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 applies to other code sets as well.
LTC	Long Term Care
MDCP	Medically Dependent Children's Program
Medicaid	Federally funded program, administered by the states, to pay for health care for eligible individuals
Medical Record Number (Trace Sequence Number)	A unique number assigned to the client by the provider to assist in the retrieval of medical records.
MESAV	Medicaid Eligibility and Service Authorization Verification application
MHMR (TDMHMR)	Texas Department of Mental Health and Mental Retardation
Modifier	A two-digit code with a specific meaning used to further define the procedure code to assist in claims adjudication.
NAT	Nurse Aid Training
National Procedure Codes	HCPCS, CPT, and dental codes representing services provided to the health care consumer.
National Provider ID	A system for uniquely identifying all providers of health care services, supplies, and equipment.
NHIC	National Heritage Insurance Company
Non-atypical	Services are those services that are considered medical/health related.
PACE	Program of All Inclusive Care for the Elderly
PAS	Personal Assistance Services
Patient Account Number (Client Control Number)	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim. Found on the 837 transactions.
Pended Claim	Suspended claim.
Per Authorized Unit Type	Units approved to equal the cost of the authorized service.
POS	Place of Service is the location where

Term	Definition
	services were obtained.
Principal Procedure Code	Code identifying the principal procedure, product or service. Found on the 837I.
Procedure Code	A standard national code used to uniquely identify a procedure, product or service delivered to the client.
Procedure Code Qualifier	Code identifying the source of the procedure code.
Provider	Person, group, or agency who is contracted to perform a service for health care consumers.
Provider Number (Provider ID)	The contract number assigned to the Long Term Care provider/provider agency by the State of Texas. Formerly known as Vendor Number. On ANSI provider systems this will be the "Secondary Provider ID"
Provider Taxonomy Code	An administrative code set for identifying the provider type and area of specialization for all health care providers.
R&S	Remittance and Status Report
RC	Respite Care
Reject	Terminology referring to electronic or system generated claims that are not accepted into the EDS-CMS system for processing.
Release of Information Code	Code indicating whether the provider has on file, a signed statement permitting the release of medical data to other organizations.
Remittance and Status Report	An electronic or paper report that informs a provider on pending, paid, denied, or adjusted claims.
Rendering Provider	The name of the provider who performed the service.
Response	An electronic message returned to the submitter of an electronic transmission that contains information about a claim or query.
Retroactive Adjustments	Adjustments initiated by the state to a claim after it has been finalized.
Revenue Code	A three (four) digit standard national code depicting the "revenue" center for the specific services being billed. Revenue codes are used to classify types of

Term	Definition
	services (i.e. accommodations, ancillary services) and in some cases, must be used in tandem with HCPCS codes. (UB-92).
Service Authorization	Approval by DHS/MHMR for a client to receive a service in a specified period of time from a contract provider.
Service Code	A code used to denote a specific service or category of service.
Service From Date	The date the service referenced in the claim or service line was initiated.
Service Group	The long term care program for which the client is eligible.
SSPD	Special Services to Persons with Disabilities
Standard Transaction	Under HIPAA, this is a transaction that complies with the applicable HIPAA standard.
Suspended Claim	A claim that has failed a program edit and is pending edit resolution before continued processing.
TDHconnect	A Windows-based application for personal computers to support provider claims submissions, Medicaid eligibility/service verification authorization inquiries, claim status inquiries, electronic remittance and status, and adjustment request submissions for Long Term Care services.
Template	A TDHconnect window that shows all of the data fields needed to submit a claim or MESAV request. Templates allow information to be saved for future use.
Texas Index of Level of Effort	The level of effort required by providers in order to provide the appropriate service(s) to a client based on an assessment of the client's medical need. A TILE is used in the calculation of the payment rate for certain services to a client. There are 11 different TILEs (values 201 through 211).
TILE	Texas Index for Level of Effort
Trace Sequence Number (Medical Record Number)	Provider submitted number allowing the provider to associate a particular response to a claim that is sent as feedback by CMS to the original claim input.
Transaction	Under HIPAA, this is the exchange of

Term	Definition
	information between two parties to carry out financial or administrative activities related to health care.
Unit	The authorized amount of service.
Unit Rate	The dollar amount applied to each unit being billed.
VA	Veteran's Affairs
Warrants	Checks or direct deposits from the Comptroller for payment to providers and vendors for services rendered to LTC clients.
DLN	Document Locator Number assigned by the state (CMS) for fiscal information sent by/to FMIS.
Warrant Number	Unique identifier given to warrants issued by the State Comptroller.
Warrant Status	Current status of the warrant.
FMIS	Fiscal Management Information System
ADA	American Dental Association
CAS	Claim Adjustment and Service Adjustment Segment of the R&S report that provides reasons, amounts, and quantities of any adjustment that the payer made to either the original submitted charge or the units related to the claim or service.
Claim Adjustment Reason Code (CARC)	Standard codes and messages that detail the reason why the payer made an adjustment to a claim payment.
CARC	Claim Adjustment Reason Code
Remittance Advice Remark Codes	Codes that represent non-financial information critical to understanding the adjudication of a claim.