Common Terminology

270 file – Eligibility verification submission file. This file, produced by your practice management system, contains demographic information for clients for which you are checking eligibility. The 837 file of the eligibility world.

271 file – Eligibility verification results file. This file contains the results of your eligibility verification check. Eligibility verification exceptions can be managed through your practice management system or the SPSI eligibility website.

277 file – Claim level acknowledgment. The 277 file will let you know which claims were accepted for adjudication by SPSI and the Payers and which were rejected up front and for what reason.

835/Remit/ERA – File returned from the payor containing adjudication information for the claims in the file. Imported into your practice management system.

837/Claim File/837(P/I) – File generated by your practice management system or our OLCE system to configure billing information into HIPAA format for submission.

Batch/File submission – Submitting 837 claim files as batches produced by your practice management system. These files are then uploaded to SPSI through the uploads page on our website or through an SFTP connection.

OLCE – Online Claim Entry – Utilizing the tools available on the SPSI client portal to build and submit claims without the use of a practice management system. Utilized mostly by lower volume providers.

Denied Claims/Denials – Claims accepted by SPSI and the payer and then adjudicated by a payer that has been denied. This can occur for a variety of reasons. Most commonly, the member's insurance was not valid at the time of service or the billed service is not covered by the denying payer.

Rejected claims/Errored Claims/Exceptions – Claims that failed either SPSI or the Payer's rules engines/edits. The file/claim was rejected prior to import by the payer and therefore the payer will usually not have any record of the file/claim. Most payers DO NOT assign a payer claim ID when they reject a file/claim. Rejected files/claims should be corrected and resubmitted as an original (paying close attention to timely filing *initial* submission rules). Examples include invalid file format, missing data in required fields, member not found, invalid address, city, state or zip code, invalid characters.

Invalid Characters – 837 files are restricted to letters, numbers, and spaces. Tabs, carriage returns, punctuation marks and special characters will often result in Rejected files containing an "invalid characters" message. Invalid characters should be removed and claim(s) resubmitted.

Payer ID – The identification number that lets SPSI know where to send your claim files. As SPSI has direct connections to certain payers, you MUST ALWAYS use the payer ID specified on the SPSI payer ID list. Claims with an invalid payer ID will be rejected.

Billing Organization – The parent organization of the company. This corresponds to box 33 of the CMS-1500 form. This will be accompanied by the billing organization NPI.

Service Facility – Where the service was performed; Box 32 from the CMS-1500 form. May be the same as the billing organization.

Rendering Provider – The name and NPI number of the person or organization who performed the service. Payers other than MMIC require a rendering provider (including an NPI #).

NPI – National Provider Identification – This is a number assigned to an organization, service location and licensed providers to identify the person performing the service. More information can be found here: https://nppes.cms.hhs.gov/#/

SFTP – Secure File Transfer Protocol – This is a secure file transfer connection that allows some practice management systems to submit 837 files directly to SPSI, bypassing the website and file uploading. Can also be used to submit eligibility files.

Practice Management System – Software designed to store client and treatment information, scheduling, billing entry, billing submission, and claim reconciliation.

EMR – Electronic Medical Record – Perform much like a practice management system to store client and treatment information, but often lacks the billing and revenue management tools found in full practice management systems.

Encounter Payments – Payments made against a block funded service. Paid claims are credited to an organization's service contract. No money changes hands. Common for organizations that receive monthly block payments.

Cash Payments – Payments received in cash via direct deposit or check. Paid after the applicable services have been rendered and billed. Method of payment for fee for service models.