Contents

[Forms and Formats 1](#_Toc511825714)

[Systems and Applications 2](#_Toc511825715)

[System Usage Terms 3](#_Toc511825716)

[BlueCard Specific 3](#_Toc511825717)

[QNXT 4](#_Toc511825718)

[Captiva 4](#_Toc511825719)

[General Terms 5](#_Toc511825720)

[Common Insurance Terms 6](#_Toc511825721)

# Forms and Formats

**CMS-1500** – A CMS 1500 form is used by physicians to submit hard-copy claims. The form is covered with red text for easy identification. When a CMS 1500 claim is viewed in Documentum, the red is stripped out.

**UB-04** – A UB-04 form is used by facilities to submit hard-copy claims. A facility is just another word for a hospital in the claims department. The form is black, white and grey easy identification. This form can also be have the same coloring as the CMS 1500.

**Captiva Coversheet -** A Captiva Coversheet is used to indicate the type of batch job which is being submitted. There are different versions of the same form for different units that are pink or blue. They all say “Captiva Coversheet” across the top.

**Top Sheet** – A Top Sheet is used to separate batches of claims. In the claims department we just call them T-Sheets The large T in the middle is there to tell the scanners “THIS IS A NEW BATCH”

**Patch-3 Sheet** – A Patch 3 sheet, refereed to around here as a “Pink Sheet” is used to separate edits or updates on the SAME claim within a batch. The large 3 in the middle is there to tell the scanners “THIS IS PART OF THE SAME CLAIM” but does NOT need to be reprocessed.

**837 Format** - The 837 Format is a HIPAA compliant format used for electronic claim submissions. 837-P is the electronic version of a CMS-1500 and the 837-I is the electronic version of the UB-04. Like CMS-1500 and UB-04 forms, it is a standard format used for digital claim submissions.

# Systems and Applications

**QNXT -** Pronounced “Q-NEXT”. QNXT is the name of the system that processes claims at HMSA. All claims submitted to HMSA eventually end up in QNXT for processing. Claims that need manual review are sent to the Claims Adjudication Department.

**BlueSquared** – BlueSquared is a web-based application to process Inter-Plan claims for the BlueCard System. If you work with BlueCard, this system will become very familiar to you in a short period of time. You will often see it referred to as “B2” in emails and documentation.

**AS/400** – The AS/400 is a mainframe system that holds claim transactions, the membership file and the provider file. It also sends reports to members and providers. (RTM’s and RTP’s) Claims department interaction with AS/400 is generally for data lookup and verification purposes.

**837 Database**  - The 837 Database is system that providers use to securely submit claims in 837 format. Providers submit electronic claims via through a secure file transfer which are then sent to QNXT for processing. All claims end up in 837 format and can be searched using an online tool.

**ASSIST** – Assist is an application built and supported by HMSA to provide a straightforward way to access claim history and member information in one place. Generally used by BlueCard staff to assist in claims processing. ASSIST DOES NOT contain any non-HMSA member information.

**IMPACT** – IMPACT is an application built and supported by HMSA to provide a way for managers and supervisors to assign specific claims (inventory) to specific staff. Staff uses IMPACT to work through the claims assigned to them

**Form97** **Database** – FORM 97 is a searchable document database application used to create, view and print Return to Provider letters.

**Captiva** – Capitva is an application that is used to scan hard copy claims and supporting documents so they can be processed electronically. Capitva uses Optical Character Recognition (OCR) to “read” the scanned documents and convert them into a computer-friendly format.

**Documentum** – Documentum is a searchable document database application for all documents captured/scanned by Captiva. Staff uses Documentum to view and verify claim documents. Only specific fields required for submission to QNXT for processing are checked.

**Aerial** – Aerial is a software application used to assist in making claim determinations. If a benefit requires pre-certification, a case is created in Aerial, supporting documents are uploaded and the Medical Management Team reviews them.

# System Usage Terms

## BlueCard Specific

**HOME -** HOME deals with all interactions involving HMSA accounts, members and other carriers. In the BlueCard world “Home” is the BCBS service area that issued your insurance card.

**HOST -** HOST deals with all provider-related functions and interactions with other host providers. In the BlueCard world “Host” is any BCBS service area you receive care in that is not the service area that issued your insurance card.

**SCCF** – Pronounced “SCUFF” A unique serial number for a claim in BlueSquared. The SCCF number consists of the local Plan code (three characters), the Julian date (seven characters), a unique sequence number assigned to the claim (five characters) and a suffix (two characters).

**SF** – SF is the standard dataset used to convey claims data from Participating Plans, Host Plans or local Plans **TO** Control Plans, Home Plans or processing sites.

**DF** – DF is the standard dataset used to convey adjudicated claims data from processing Plans to local Plans. The DF is an inter-Plan electronic explanation of benefits.

**RF** – RF is the standard dataset used to convey paid claims data from local Plans to processing Plans.

**Alpha Prefix** - An Alpha Prefix consists of the first 3 Letters of a member ID. There are lots of alpha-prefixes. You will have access to a reference sheet that lists all of them.

**GI** - GI stand for General Inquriy. A GI is created to ask another provider a question regarding a claim. Think of GI’s as asking a question about a claim in BlueSquared.

**PPE**  - Plan Profile Error. If an alpha prefix cannot be validated this is the error you would see in BlueSquared.

**SLA** - Stream Line Inquiry (Adjustment)

**MEDREC** – Medical Records Request

**PX** - Plan Connection. 3rd Party that hosts our copy of the BlueSquare Application and associated data.

**Claims Administration (SF and DF)** – Part of Blue Squared where you manually create SF’s and DF’s. Listing of these ITS edits is provided as a report.

## QNXT

**CID** – Claim Identifier

**QID** - QNXT Identifier

**Plan CRN/DC**N – Contains both electronic and captiva

**Reversal** – Backs out an already processed claim, resets all dollar amounts

## Captiva

**DCN** – Document Control Number

**TBN –** Teleform Batch Number - Only used in documentum

**Captiva Number -**

# General Terms

**Pend** – Indicates a claim has one or more edits that need review.

**Inventory** – Claims waiting for adjustment, contain at least one pend status.

**Edit** – on a claim, an issue QNXT identified that requires review by an examiner

**RTM –** Report to Member. Document sent to member that shows how much HMSA paid for services and the amount you’re responsible for. The Report to Member (RTM) is an explanation of benefits and is **not a bill** for services or supplies.

**RTP** – Report to Provider. Document sent to provider that provides a list of approved, adjusted, denied, and in-process claims. It also provides totals of approved, adjusted and denied claims as well as the total amount of the check/deposit.

**EDI 835** - HIPAA compliant, electronic payment and benefit information to providers.

**CIRF** – Customer Inquiry Resolution File. Created by Customer Service to track EVERY phone call that comes into HMSA, regardless of whether it was resolved immediately or not.

**PHI** – Protected Health Information (Health and Human Services Term)

**CMI** – Confidential Member Information (PII and NPFI) DEAD OR ALIVE ☺

# Common Insurance Terms

**Allowable charge—**sometimes known as the "allowed amount," "maximum allowable," and "usual, customary, and reasonable (UCR)" charge, this is the dollar amount considered by a health insurance company to be a reasonable charge for medical services or supplies based on the rates in your area.

**Benefit—**the amount payable by the insurance company to a plan member for medical costs.

**Benefit level—**the maximum amount that a health insurance company has agreed to pay for a covered benefit.

**Benefit year—**the 12-month period for which health insurance benefits are calculated, not necessarily coinciding with the calendar year. Health insurance companies may update plan benefits and rates at the beginning of the benefit year.

**Claim—**a request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.

**Coinsurance—**the amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage. For example, if the insurance company pays 80% of the claim, you pay 20%.

**Coordination of benefits—**a system used in group health plans to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100% of the claim.

**Copayment—**one of the ways you share in your medical costs. You pay a flat fee for certain medical expenses (e.g., $10 for every visit to the doctor), while your insurance company pays the rest.

**Deductible—**the amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.

**Dependent—**any individual, either spouse or child, that is covered by the primary insured member’s plan.

**Drug formulary—**a list of prescription medications covered by your plan.

**Effective date—**the date on which a policyholder's coverage begins.

**Exclusion or limitation—**any specific situation, condition, or treatment that a health insurance plan does not cover.

**Explanation of benefits—**the health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

**Group health insurance—**a coverage plan offered by an employer or other organization that covers the individuals in that group and their dependents under a single policy.

**Health maintenance organization (HMO)**  
A health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific, in-network plan providers.

**Health savings account (HSA)—**a personal savings account that allows participants to pay for medical expenses with pre-tax dollars. HSAs are designed to complement a special type of health insurance called an HSA-qualified high-deductible health plan (HDHP). HDHPs typically offer lower monthly premiums than traditional health plans. With an HSA-qualified HDHP, members can take the money they save on premiums and invest it in the HSA to pay for future qualified medical expenses.

**In-network provider—**a health care professional, hospital, or pharmacy that is part of a health plan’s network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their way.

**Individual health insurance—**health insurance plans purchased by individuals to cover themselves and their families. Different from group plans, which are offered by employers to cover all of their employees.

**Medicaid**—a health insurance program created in 1965 that provides health benefits to low-income individuals who cannot afford Medicare or other commercial plans. Medicaid is funded by the federal and state governments, and managed by the states.

**Medicare**—the federal health insurance program that provides health benefits to Americans age 65 and older. Signed into law on July 30, 1965, the program was first available to beneficiaries on July 1, 1966 and later expanded to include disabled people under 65 and people with certain medical conditions. Medicare has two parts; Part A, which covers hospital services, and Part B, which covers doctor services.

**Medicare supplement plans**—plans offered by private insurance companies to help fill the "gaps" in Medicare coverage.

**Network**—the group of doctors, hospitals, and other health care providers that insurance companies contract with to provide services at discounted rates. You will generally pay less for services received from providers in your network.

**Out-of-network provider—**a health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers.

**Out-of-pocket maximum—**the most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

**Payer—**the health insurance company whose plan pays to help cover the cost of your care. Also known as a carrier.

**Pre-existing condition—**a health problem that has been diagnosed, or for which you have been treated, before buying a health insurance plan.

**Preferred provider organization (PPO)—**a health insurance plan that offers greater freedom of choice than HMO (health maintenance organization) plans. Members of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers inside the network.

**Premium—**the amount you or your employer pays each month in exchange for insurance coverage.

**Provider—**any person (i.e., doctor, nurse, dentist) or institution (i.e., hospital or clinic) that provides medical care.

**Rider—**coverage options that enable you to expand your basic insurance plan for an additional premium. A common example is a maternity rider.

**Underwriting—**the process by which health insurance companies determine whether to extend coverage to an applicant and/or set the policy's premium.

**Waiting period—**the period of time that an employer makes a new employee wait before he or she becomes eligible for coverage under the company's health plan. Also, the period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain pre-existing conditions.