General Regulations

Participating providers shall submit all claims for payment for Covered Services performed for Blue Cross and Blue Shield (BCBS) members utilizing claim forms as set forth in The Billing and Reimbursement section of this manual. In addition to the instructions in this section and other sections of the manual, participating providers (Provider) shall adhere to the following policies with respect to filing claims for Covered Services to BCBS members:

1. A Provider performing covered services for a BCBS member shall be fully and completely responsible for all statements made on any claim form submitted to BCBSIL by or on behalf of the Provider. A Provider is responsible for the actions of staff members or agents.

2. All Covered Services provided for and billed for BCBS members by Providers shall be performed personally by the Provider or under his/her direct and personal supervision and in his/her presence, except as otherwise authorized and communicated by BCBSIL. Direct personal supervision requires that a provider be in the immediate vicinity to perform or to manage the procedure personally, if necessary.

3. A Provider will endeavor to file complete and accurate claims with BCBSIL. In the event any Provider has received, either from BCBSIL or from the member, an amount in excess of the amount determined by BCBSIL to be payable with respect to services performed, due to failure to file complete and accurate claims, such excess amount shall be returned promptly to BCBSIL or to the member, as the case may be. In the event such overpayments are not voluntarily returned, BCBSIL will be permitted to deduct overpayments (whether discovered by the Provider or BCBSIL) associated with the failure to file claims accurately and completely from future BCBSIL payments for a period of time not to exceed 18 months from the date the payment was received except, in instances of fraud, as to which there will be no time limit on recoveries.

   BCBSIL considers fraudulent billing to include, but not be limited to, the following:
   - Misrepresentation of the services provided to receive payment for a noncovered service;
   - Billing in a manner which results in reimbursement greater than what would have been received if the claim were properly filed; and/or
   - Billing for services which were not rendered.

4. To the greatest extent possible, Providers shall report services in terms of the procedure codes listed in the most recent version of Current Procedural Coding manuals and ICD-9 reference books. In unusual cases, a description of the service, a copy of the hospital/medical records or other appropriate documentation should be submitted.

5. Provider shall not bill or collect from a member, or from BCBSIL, charges itemized and distinguished from the professional services provided. Such charges include, but are not limited to, malpractice surcharges, overhead fees or facility fees, concierge fees or fees for completing claim forms or submitting additional information to BCBSIL.

6. The determination as to whether any Covered Service meets accepted standards of practice in the community shall be made by BCBSIL in consultation with providers engaged in active clinical practice. Fees for Covered Services deemed not to meet accepted standards of practice shall not be collected from the member.

7. BCBSIL has the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary. The time period for such recoveries will be consistent with those set out in paragraph #3 above. A Provider shall render Covered Services as necessary and appropriate for the patient's condition and not mainly for the convenience of the member or Provider. In the case of diagnostic testing, the tests should be essential to and be used in the diagnosis and/or management of the patient's condition. Services should be provided in the most cost effective manner and in the least costly setting required for the appropriate treatment of the member. Fees for Covered Services deemed not medically necessary shall not be collected from the member, unless the member requests the service(s), the participating provider informs the member of his or her financial liability and the member chooses to receive the service(s). The participating provider should document such notification to the member in the provider's records.

8. A participating Provider may, at all times, bill a BCBS member for non-covered services. The determination as to whether any services performed by a Provider for a BCBS member are covered by a Blue Cross and Blue Shield Agreement, and the amount of payment for such services, shall be made by BCBSIL.

9. BCBSIL may request medical records and/or conduct site visits to review, photocopy and audit a Provider's records to verify medical necessity and appropriateness of payment without prior notice. Such review may be delegated to contractors or governmental agencies. BCBSIL will not reimburse a Provider for the cost of duplicating medical records requested for these purposes.

10. A Provider may not refer a BCBS member to a Provider that does not participate in BCBSIL absent a written waiver from the member or the approval of BCBSIL. Referral to any other provider/facility, regardless of whether that provider/facility is a participating provider, with which the Provider has a business interest, must be acknowledged to the patient in writing at the time of the referral.

11. A Provider is prohibited from paying or receiving a fee, rebate or any other consideration in return for referring a BCBS member to another provider, or in return for furnishing services to a member referred to him or her.

12. A Provider will ensure that Covered Services reported on claim forms are supported by documentation in the medical record, and adhere to the general principles of medical record documentation, including the following, if applicable to the specific setting/encounter:
    - Medical records should be complete and legible;
    - Documentation of each patient encounter should include:
        - Reason for the encounter and relevant history;
        - Physical examination findings and prior diagnostic test results;
        - Assessment, clinical impression, and diagnosis;
        - Plan for care;
        - Date and legible identity of observer;
    - If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

13. Every BCBS member shall be supplied with an appropriate identification card and participating providers shall be entitled to require members to present their identification card when services are requested. It is recommended that photo identification be required each and every time services are provided.

14. Precertification of services may be required in accordance with a member's contract with BCBSIL. Services not precertified could result in claims being paid at a lesser benefit level or in claims payment denial and members must be held harmless. If it is determined that a favorable precertification or predetermination decision was based on inaccurate or misleading information submitted by the Provider or the member, BCBSIL may refuse to pay the claim or seek recovery of paid claims. Charges for services which are not paid as the result of submission of false or inaccurate information by the Provider shall not be collected from the member.

15. A Provider is expected to complete all necessary information on the claim forms which will facilitate Coordination of Benefits with other third party payers by BCBSIL.

16. Standard BCBSIL benefits are not available for services rendered by providers to their immediate family members. An immediate family member is defined as:
    - current spouse
    - eligible domestic partner
    - parents and step-parents
    - children and grandchildren
    - siblings (including natural, step, half or other legally placed children)

    BCBSIL does not expect to receive claims for these services and will not make payment on claims submitted for services rendered by or for immediate family. Should it be determined that a benefit has been paid in error, we will request a refund of the original payment.

17. Providers should be knowledgeable of the BCBSIL Medical Policies. Medical Policies serve as one of the sets of guidelines for coverage decisions. Member Benefit Plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations and to applicable state and/or federal law. Go to the Provider Library at http://www.bcbsil.com/provider/index.htm to view all active, pending and draft medical policies.

Effective May 1, 2010, the following provisions apply to all contracted professional PPO providers, and do not affect institutional or HMO providers.

Disputes

I. Any disputes arising out of the terms of the Provider Agreement shall be governed by and subject to the laws of the State of Illinois.

II. In order to avoid the cost and time consuming nature of litigation, any dispute between Plan and Contracting Provider arising out of, relating to, involving the interpretation of, or in any other way pertaining to this Agreement or any prior Agreement between Plan and Contracting Provider shall be resolved using alternative dispute resolution mechanisms instead of litigation. Plan and Contracting Provider agree and acknowledge that it is their mutual intention that this provision be construed broadly so as to provide for individual mediation and/or arbitration of all disputes arising out of their relationship as third-party payer and provider. The parties further agree that resolution of any dispute pursuant to this Agreement shall be in accordance with the procedures detailed below.

A. Initial Resolution by Meeting or Mediation of Dispute

1. Plan or Contracting Provider, as the case may be, shall give written notice to the other of the existence of a dispute (the “Initial Notice”).
2. If Plan and Contracting Provider mutually agree that a meeting to attempt to resolve the dispute would be advantageous, representatives of Plan and Contracting Provider shall meet not later than thirty (30) calendar days after delivery of the Initial Notice in order to attempt to resolve the dispute. Subsequent meetings may be held, if mutually agreed.
3. If no meeting is mutually agreed, or if the dispute is not resolved at any meetings held, the party giving the Initial Notice shall submit the dispute to mediation by an organization or company specializing in providing neutral, third-party mediators. The mediation process shall be coordinated by the submitting party with the mediator and shall be subject to the following agreed-upon conditions:

    a. The parties agree to participate in the mediation in good faith;

b. The parties agree to have present at the mediation one or more individuals with decision-making authority regarding the matters in dispute. Either party may, at its option, be represented by counsel. Contracting Provider may, at its option, also have present at the mediation a representative of any professional society of which it is a member;
c. The mediation will be held in Chicago, Illinois, within sixty (60) days of the submission to mediation, unless the parties mutually agree on a later date or a different venue;
d. The parties shall each bear their own costs and shall each pay one-half of the mediator's fees and costs, unless the mediator determines that one party did not participate in the mediation in good faith, in which case that party shall pay all of the mediator's fees and costs;
e. The parties agree that the obligation to mediate (but not the obligation to arbitrate) is not applicable to any dispute that was pending in any court on the effective date of this Agreement, or that had been submitted to binding arbitration on or before the effective date of this Agreement.

B. Binding Arbitration

In the event mediation is not successful in resolving the dispute, either Plan or Contracting Provider, on Contracting Provider's own behalf and not as a representative of a purported class, may submit the dispute to final and binding arbitration under the Rules of Procedure of Arbitration of the American Health Lawyers Association, subject to the following:

1. The arbitration shall be conducted by a single arbitrator selected by the parties from a list furnished by the American Health Lawyers Association. If the parties are unable to agree on an arbitrator from the list, the arbitrator shall be appointed by the American Health Lawyers Association.
2. The arbitrator shall be required to render a written decision resolving all disputes, and designating one party as the "prevailing party."
3. Except in the case of fraud, no arbitration decision may require any adjustment in reimbursements or payments respecting any dispute involving services rendered more than eighteen (18) months prior to receipt of the Initial Notice.
4. The costs of arbitration, including the arbitrator's fee and any reporting or other costs, but excluding lawyers', consultants' and witness fees, shall be borne by the non-prevailing party unless the arbitrator determines as part of his or her award that such allocation is inequitable under the totality of the circumstances.
5. Contracting Provider acknowledges that this provision agreement precludes Contracting Provider from filing an action at law or in equity and from having any dispute covered by this Agreement resolved by a judge or jury. Contracting Provider further acknowledges that this arbitration provision precludes Contracting Provider from participating in a class action or class arbitration filed by any other provider or any other plaintiff claiming to represent Contracting Provider or Contracting Provider's interest. Contracting Provider agrees to opt-out of any class action or class arbitration filed against Plan that raises claims covered by this agreement to arbitrate, including, but not limited to class arbitrations that are currently pending.

C. Subject to the provisions of the Manual, Contracting Provider may elect to subject certain disputes regarding claim payment to a Billing Dispute External Review Process as described therein. The resulting determination with respect to payment of any claims that are the subject of disputes so submitted shall be binding on the parties and not be subject to other provisions contained herein for dispute resolution.

D. Subject to the provisions of the Manual, Contracting Provider may, if Contracting Provider is acting on behalf of a Covered Person, elect to subject certain disputes concerning a determination by Plan that a service is not or will not be a Covered Service because it is not medically necessary or is experimental or investigational in nature ("Adverse Determination") to an External Review process described in the Manual. The resulting determination with respect to the appropriateness of such Adverse Determination shall be binding on the parties and not be subject to the other provisions contained herein for dispute resolution.

E. With respect to any arbitration provided for in this Agreement, Plan shall refund any applicable filing fees and arbitrators' fee paid by Contracting Provider in the event that Contracting Provider is the prevailing party; provided, however, that this refund of filing fees and arbitrators' fees shall not apply with respect to any arbitration proceeding in which Contracting Provider purports to represent any health care providers outside of Contracting Provider. Mediation or arbitration provided for in this Agreement will be held within a fifty (50) mile radius from the Contracting Provider's principal office, unless Plan and Contracting Provider mutually agree to an alternate location.

Appeal Process (External Review)

Any individual physician or physician group may submit a Billing Dispute for an External Review when the Physician or Physician Group has exhausted all BCBSIL internal appeals for resolution of Billing Disputes or, when the amount in dispute exceeds $500. For any Billing Disputes that a physician or physician group submits for External Review, the physician or physician group submitting the dispute shall pay to BCBSIL a filing fee equal to $50 for amounts in dispute between $500 and $1,000. For amounts in dispute greater than $1,000, the filing fee shall be equal to $50 plus 5% of the amount by which the amount in dispute exceeds $1,000, but in no event shall the fee be greater than 50% of the cost of the review.

Timely Filing*

Blue Cross and Blue Shield of Illinois Facility Providers

Claims must be filed with Blue Cross and Blue Shield of Illinois on or before December 31st of the calendar year **following** the year in which the services were rendered. Services furnished in the last quarter of the year (October, November, and December), are considered to be furnished in the following year. For example, a claim with a service date between 10/01/08 and 09/30/09 must be filed before 12/31/10. Claims not filed within the above time frames will not be eligible for payment. However, there are some employer groups that have different and specific time frames for filing claims. This information may be obtained when calling for eligibility and benefits.

Professional PPO and Blue*Choice* Select Providers*:

The Contracting Provider agrees to bill the Plan in a timely manner and in a method acceptable to the Plan for payment prior to charging the Covered Person for any deductible or coinsurance amount. The Plan agrees to pay the Contracting Provider directly, on a timely basis, for Covered Services rendered to a Covered Person as described in the Covered Person's applicable health care benefit contract.

In no event will the Plan, its Designee, a Covered Person, a Covered Person's representative, a Payor, or any other person or entity be obligated to pay all or any portion of any Claim for Covered Services that is not received by the Plan within the one hundred eighty (180) day period following:

i. The date of discharge or transfer for inpatient Health Services,
ii. The date of service for all other Health Services, that are not inpatient, or
iii. 180 days after the date of the Contracting Provider's receipt of the explanation of benefits from primary payor when Plan is the secondary payor.

The Plan will consider any request for a reasonable extension of the 180 day time period for filing claims, on a case by case basis, if the Contracting Provider provides notice to Plan along with appropriate evidence, of circumstances beyond the reasonable control of the Contracting Provider that resulted in the delayed submission of the claim. The Plan reserves the right, in its sole discretion, to determine whether a reasonable extension of the timely filing requirement should be granted.

*Effective April 1, 2010.

Coordination of Benefits

All payments made by BCBSIL are subject to the Coordination of Benefits (COB) provisions of the applicable contracts. When a covered person has other coverage under another group plan or any deductible, copayment or coinsurance balance, the total amount payable by the plan and the secondary carrier cannot exceed the Maximum Allowance or the provider's fee, whichever is less.

Order of Benefit Determination

1. If an insurance plan **does not** contain a provision for coordination of benefits, then that plan will have primary responsibility for the payment of benefits.

2. If an insurance plan **does** contain a provision for coordination of benefits, the rules for establishing the order of benefit determination are:

   - The **Blue on Blue Rule** applies when two members (e.g., husband and wife), are covered separately by Blue Cross and Blue Shield Plan(s). The member's Plan is primary when the member is the patient and the spouse's Plan is secondary.
   - The **Birthday Rule** applies when a dependent (e.g., a child) is covered by two different members on separate plans when the employer groups consist of 10 or more employees. In this case:
     - The primary Plan is the Plan of the member whose birth date (month/day) occurs earliest in the calendar year
     - If both members share the same birth date, the primary Plan is the Plan covering the member for the longer period of time.
   - The Gender Rule applies when a dependent (e.g., a child) is covered by two different members on separate Plans when the employer groups consist of less than 10 employees. In this case, the Plan that covers the dependent of a male member has primary responsibility over the Plan that covers the dependent of a female member.

   - When a dependent (e.g., a child) is covered by two different members on separate employer group Plans, one Plan following the Birthday Rule and the other Plan following the Gender Rule, the Gender Rule Plan prevails.

   - When the members (i.e., the parents) of the dependent are divorced or separated, neither the Birthday Rule nor the Gender Rule applies. Instead:

     - The Plan of the parent with custody is primary.
     - If the parent with custody is remarried, the Plan of the spouse (the step-parent) is secondary.
     - The Plan of the parent without custody pays last.

Rule	Definition	Determination
Blue on Blue	Husband and wife each separately covered by BCBS Plan	Patient's Plan is primary and spouse's Plan is secondary
Gender	Applies to dependent children covered by two employer group Plans each of less than 10 employees	The father's Plan is primary and the mother's Plan is secondary
Birthday	Applies to dependent children covered by two employer group Plans each of more than 10 employees	The Plan of the parent whose birthday falls earlier in the year (month & day) is primary

MEDICARE Crossover

Crossover is the automatic process by which Medicare sends an electronic supplemental claim to private insurers. The electronic claim contains claim and remittance data used to calculate secondary payment liability. The claim and remittance information is released to an insurer based on a membership listing that the insurer sends to Medicare.

The Centers for Medicare & Medicaid Services (CMS) has consolidated the Medicare crossover process from many crossover contractors to one contractor, Coordination of Benefits Contractor (COBC). Under this arrangement, COBC sends all supplemental claims to private insurers.

It is not necessary in most instances for providers to submit either an electronic or a paper claim to Blue Cross and Blue Shield, because we receive the electronic crossover claim. There are some situations when a claim does not crossover because the member's Health Insurance Claim Number (HICN) does not match our membership file. It is only when a claim does not crossover that you need to file an electronic claim to BCBSIL.

We will reject **paper** Secondary claims when we have established a verified Crossover arrangement for a member through a positive match with the member's Medicare Health Insurance Claim Number (HICN). In those situations where there is no positive match, we will continue to process Medicare Primary, Blue Cross and Blue Shield Secondary claims with existing procedures.

Follow These Steps before Submitting a Supplemental Claim to Us:

1. Check to see if the claim automatically crossed over:
   - The Medicare Remittance Advice will contain a message that the claim was forwarded through the Crossover process.
   - Crossover claim payments are highlighted with the message, "Medicare Crossover Claim" on the Provider Claim Summary (PCS) and on the Electronic Remittance Advice (ERA)

   Note: COBC will not crossover supplemental claims until claims have left the Medicare 14 day payment floor. For Example:
   - Electronic claims processed on July 7, 2009, will be released to the supplemental insurer after a 14 day payment floor, July 21, 2009.
   - Paper claims processed on July 7, 2009, will be released after the new 29-day payment floor instituted under the Deficit Reduction Act (DRA), Aug. 5, 2009.

2. If the claim did not crossover, you may submit it **electronically**. For more information on the electronic submission of **professional** Medicare Primary, Blue Cross and Blue Shield Secondary claims, you may access the Medicare B Supplemental Claim Submission Reference Guide located at www.bcbsil.com/provider/referenceguide.htm. This reference guide provides the requirements for submitting electronically.

3. Do not re-submit a rejected claim by paper; because it will deny as a duplicate. You must submit the rejected claim for review. Please follow the usual review process by calling the Provider Telecommunications Center at (800) 972-8088, or completing a Provider Review Form located on the BCBSIL Provider Web site at www.bcbsil.com/provider.

Facility Providers

Claim Filing: UB-04

Facility providers filing claims with BCBSIL should use the **UB-04** claim form. For assistance with completing the UB-04 claim form, please refer to the UB-04 User Guide located on our provider Web site at www.bcbsil.com/provider. For additional information on the UB-04 billing form, visit the National Uniform Billing Committee (NUBC) Web site at **www.nubc.org.**

Claim Submission

Facility providers should submit claims electronically to BCBSIL for all members including those from other BCBS Plans.
Paper claims should be sent to:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

Reimbursement

When a claim is submitted for services rendered to a Blue Cross subscriber, the claim is adjudicated and the total covered charges are paid up front. Providers receive a Provider Claim Summary (PCS) or an Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS) once the claim has been adjudicated. The ERA is an electronic file that contains claim payment and remittance information on all claims that were paid, the amount of each payment, and the status of the claims that were processed. The paper PCS contains he same information, and the EPS is an electronic print image of the PCS. An example of the paper PCS is contained on the following pages. To obtain more information about the ERA, EPS, as well as Electronic Funds Transfer (EFT), please visit our Web site at www.bcbsil.com/provider/ec/eft.htm.

The terms of each provider agreement allow for a contracted payment to be made. The calculation of the contracted payment varies depending on the provider type:

- Hospitals
- Extended Care Facilities
- Coordinated Care Facilities
- Hospices
- Surgicenters
- Renal Facilities

Payment is based on a negotiated rate; inpatient claims are usually based on a per diem negotiated rate and outpatient claims are based on a fee schedule, case risk or a percentage of charges. Providers must refer to their individual contract terms for specifications of their contract. The difference between the contracted payment and the total covered Blue Cross charge is the contractual allowance due to Blue Cross. All contracted Blue Cross providers receive an Experience Report listing all claims, accompanied by a cover letter that summarizes the figures for the year-to-date. The cover letter includes the repayment terms. The amount due must be paid within 30 days, unless providers participate in the Uniform Payment Program (UPP).

Provider Claim Summary (PCS)

The Provider Claim Summary (PCS) is a notification statement sent with the payment to Blue Cross providers after the processing of a claim has been completed. There are different Provider Claim Summaries. The content of each summary varies based upon the subscriber's benefit plan and the services rendered. The voucher may include multiple transactions. The sample Provider Claim Summary on the next page should be used as a reference. A legend describing each field follows the PCS example.

PPO Provider Claim Summary Example

BlueCross BlueShield of Illinois

A Member of the Blue Cross and Blue Shield Association
An Association of Independent Blue Cross and Blue Shield Plans

300 East Randolph Street
Chicago, Illinois 60601-5099

DATE: MM/DD/YY (1)
PROVIDER NUMBER: 0000000000 (2)
VOUCHER NUMBER: 123456789 (3)
TAX IDENTIFICATION NUMBER: 987654321 (4)

(5) **ABC FACILITY**
123 MAIN STREET
ANYTOWN, IL 60000

PROVIDER CLAIM SUMMARY

ANY MESSAGES WILL APPEAR ON PAGE 2
********INPATIENT

(6) PATIENT:	JOHN DOE	(8) PATIENT NO:	000000	(10) ADMIT DATE	(11) FROM DATE	(12) END DATE
(7) CLAIM NO:	0000000000000000X	(9) ICN NO:		04/01/09	05/02/09	05/29/09

(13) DAYS TRT	(14) ORIGIN CODE	(15) PROVIDER CHARGE	(16) BLUE CROSS PAID	(17) TOTAL AMOUNT PAID	(18) MANAGED CARE DEDUCTION(S)	(19) TOTAL PATIENT PORTION
012	03	$1,200.00	$960.00	$960.00	$0.00	$240.00

MESSAGES/REASONS: OA

PATIENT:	JOHN DOE	PATIENT NO:	000000	ADMIT DATE	FROM DATE	END DATE
CLAIM NO:	0000000000000000X	ICN NO:		03/26/09	04/01/09	04/30/09

DAYS TRT	ORIGIN CODE	PROVIDER CHARGE	BLUE CROSS PAID	TOTAL AMOUNT PAID	MANAGED CARE DEDUCTION(S)	TOTAL PATIENT PORTION
010	03	$1,000.00	$800.00	$800.00	$0.00	$200.00

MESSAGES/REASONS: OA

PROVIDER CLAIMS AMOUNT SUMMARY

(20) PROVIDER CHARGES:	$2,200.00	I	(23) PATIENT PORTION:	$440.00
(21) BLUE CROSS AMOUNT PD:	$1,760.00	I	(24) AMOUNT PAID:	$1,760.00
(22) MANAGED CARE DEDUCTION(S):	$0.00	I	(25) NUMBER OF CLAIMS:	02

	$80.00	AMOUNT OVER U & C:	$0.00
AMOUNT PAID TO PROVIDER:	$50.00	AMOUNT OF SERVICES NOT COVERED:	$19.00
AMOUNT PAID TO MEMBER:	$0.00	AMOUNT PREVIOUSLY PAID:	
NUMBER OF CLAIMS:	1	AMOUNT OVER MAXIMUM ALLOWANCE:	$11.00

ORIGIN CODE 01 IS HCMS ORIGIN CODE 02 IS SCMS ORIGIN CODE 03 IS BLUE CHIP

(26)
MESSAGES/REASONS:
(OA) A CONTRACT COINSURANCE HAS BEEN TAKEN

Provider Claim Summary (PCS) Field Explanations

1	**Date**	Date the summary was finalized
2	**Provider Number**	The physician's National Provider Identifier number
3	**Voucher Number**	The number assigned to the check for this voucher
4	**Tax Identification Number**	The number which identifies your taxable income
5	**Provider Name & Address**	The provider's name and address that rendered the services
6	**Patient**	The name of the individual who received the service
7	**Claim Number**	The Blue Cross number assigned to the claim
8	**Patient Number**	The patient's account number assigned by the provider
9	**ICN Number**	The number that identifies the group and member insured by BCBSIL
10	**Admit Date**	The date the patient was admitted to the provider for care (the Start of Care date could be different than the From/End dates).
11 **12**	**From Date/End Date**	Indicates the beginning and ending dates of services rendered
13	**Days Trt**	The total number of service days or treatments
14	**Origin Code**	BCBS identifying system codes
15	**Provider Charge**	The amount billed for each service
16	**Blue Cross Paid**	The amount paid for each service
17	**Total Amount Paid**	The amount paid to the provider
18	**Managed Care Deduction(s)**	The amount of any applicable cost containment or PPO reductions
19	**Total Patient Portion**	The total amount that is the patient's responsibility
20	**Provider Changes**	Total provider charges for this voucher
21	**Blue Cross Amount Paid**	Total Blue Cross payment for this voucher
22	**Managed Care Deduction(s)**	Total cost containment or PPO reductions for this voucher
23	**Patient Portion**	Total amount for which the patient is responsible
24	**Amount Paid**	Total amount paid for claims on this voucher
25	**Number of Claims**	Number of claims for this voucher
26	**Messages/Reasons**	This area includes the narrative for any codes relating to a denial of services or reduction in the amount paid

Reporting

Experience Report

An Experience Report is generated each month for all Blue Cross subscribers who received services at facilities covered by a Blue Cross contract. The Experience Report lists all claims and a cover letter that summarizes the figures for the year-to-date. The cover letter includes the repayment terms. The amount due must be paid within 30 days, unless providers participate in the Uniform Payment Program (UPP), in which case the amount due is deducted from the next UPP check.

Examples of an Experience Report and Legend are on the following pages.

Experience Report Sample Cover Letter

BlueCross BlueShield of Illinois

A Member of the Blue Cross and Blue Shield Association
An Association of Independent Blue Cross and Blue Shield Plans

300 East Randolph Street
Chicago, Illinois 60601-5099

APR 26 09

MARY M. SMITH
CHIEF FINANCIAL OFFICER
ABC FACILITY
123 MAIN STREET
ANYTOWN, ILLINOIS 60000

INTERIM
RECONCILIATION

DEAR MARY M. SMITH:

PLEASE FIND ATTACHED A SUMMARY OF YOUR PPO CLAIM EXPERIENCE FOR PPO CLAIMS PAID DURING THE MONTH ENDED 03/31/08, RELATED TO THE PPO PERIOD THAT ENDED ON 12/31/07.

BASED ON THE ATTACHED INTERIM PPO RECONCILIATION, THE AMOUNT DUE FROM YOUR FACILITY IS $7,694.58. BEGINNING WITH YOUR 05/03/01 UPP CHECK, $1,923.64 WILL BE DEDUCTED FROM YOUR NEXT FOUR UPP CHECKS ON THE PPO ALLOWANCE LINE.

IF YOU HAVE ANY QUESTIONS, CALL JOHN Q. PUBLIC, SENIOR REIMBURSEMENT SPECIALIST, AT (312) 653-XXXX.

ABC FACILITY
B.C. NO. 000
YTD FOR THE PERIOD 01/02/09 THRU 12/31/09

TOTAL PPO ALLOWANCES	LESS: TOTAL PPO COLLECTIONS	AMOUNT DUE (FROM) TO BLUE CROSS	DIVIDED BY 4 WEEKS EQUALS UPP ADJUSTMENT (INCR)/DECR
$164,129.08	$156,434.50	7,694.58	1,923.64

Sample PPO Experience Report

HEALTH CARE SERVICE CORPORATION
PPO EXPERIENCE REPORT
PPO DISCOUNT STATUS: Y
PROVNAME: ABC FACILITY
BLUE CROSS NO. 00000000000
REPYEAR: 12/31/2009
SETTING: INPATIENT CLAIM TYPE: INPATIENT

FOR THE MONTH ENDED 2009/08/31
With Bonus Settlement for the Month Ended 2009/06/30

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
LAST NAME	F I	PROVIDER PATIENT NUMBER	SUB No.	GROUP NO.	ADMIT DATE	DISCH DATE	CA-SES	TOTAL DAYS	MED SURG DAYS	ICU DAYS	PSY DAYS	SUB ABUSE DAYS	TYPE	PRIMARY ICD-9 PROCCD	DRG IP CPT OP	SERV UNITS	COVERED CHARGES	TOTAL OTHER PMTS APPLIED	NET COV CHARGES	PPO PAYMENT	PPO ALLOWANCE
ADAMS	J	000000000	00000000111111111	123456	mm/dd/yy	mm/dd/yy	1	1	1	0	0	0	MLT DIEM	9604	449	0	14,817.37	2,798.00	11,238.97	.00	11,238.97
ADAMS	J	000000000	00000000111111111	123456	mm/dd/yy	mm/dd/yy	-1	-1	-1	0	0	0	MLT DIEM	9604	449	0	-14,817.37	-2,798.00	-11,238.97	.00	-11,238.97
BLACK	P	000000000	00000000333333333	XOP123	mm/dd/yy	M m/dd/yy	0	0	0	0	0	0	OB	741	371	0	2,581.20	.00	2,581.20	.00	2581.20
BURNS	S	000000000	00000000888888888	123456	mm/dd/yy	mm/dd/yy	1	5	5	0	0	0	LESSEROF	7935	210	0	10,307.24	313.19	9,994.05	9,994.05	.00
COLLINS	R	000000000	00000000444444444	123456	mm/dd/yy	mm/dd/yy	0	0	0	0	0	0	OB	640	391	0	2,974.00	.00	2,974.00	1,827.00	1,147.00
DAVIS	K	000000000	00000000555555555	123456	mm/dd/yy	mm/dd/yy	1	8	5	3	0	0	MLT DIEM	5779	303	0	92,082.22	25,126.00	305.69	.00	305.69
DOE	J	000000000	00000000666666666	P12345	mm/dd/yy	mm/dd/yy	1	2	0	2	0	0	MLT DIEM	3761	111	0	9,364.20	904.52	8,459.68	2,807.48	5,652.20
TOTAL CLAIM							3	15	10	5	0	0					117308.86	26344.42	24314.62	14628.53	9686.09
TOTAL INCURRED THRU 2005/12/31							3	15	10	5	0	0					117308.86	26344.42	24314.62	14628.53	9686.09
ADKINS	J	000000000	00000000999999999	123456	mm/dd/yy	mm/dd/yy	0	0	0	0	0	0	OB		391	0	1,889.00	84.80	1,804.20	1,193.20	611.00
ADAMS	M	000000000	00000000111111111	P12345	mm/dd/yy	mm/dd/yy	1	8	8	0	0	0	MLT DIEM		089	0	36,805.00	.06	36,804.94	23,559.94	13,245.00
BROWN	P	000000000	00000000222222222	XOP123	mm/dd/yy	mm/dd/yy	1	7	7	0	0	0	MLT DIEM	3950	554	0	79,217.80	100.00	79,117.80	20,515.00	58,602.80
COLLINS	R	000000000	00000000333333333	123456	mm/dd/yy	mm/dd/yy	1	3	0	3	0	0	LESSEROF		390	0	11,461.00	.00	11,461.00	11,461.00	.00
DAVIS	K	000000000	00000000444444444	123456	mm/dd/yy	mm/dd/yy	1	1	1	0	0	0	MLT DIEM		143	0	19,817.00	53.20	19,763.80	2,891.80	16,872.00
EVANS	S	000000000	00000000555555555	P12345	mm/dd/yy	mm/dd/yy	-1	-2	0	-2	0	0	MLT DIEM	9671	475	0	-41,309.00	-1,854.71	-39,454.29	-5,955.29	-33,499.00
OTOOLE	M	000000000	00000000666666666	XOP123	mm/dd/yy	mm/dd/yy	0	0	0	0	0	0	OB		391	0	2,096.00	94.51	2,001.49	1,183.49	818.00

Page 1

Refer to field explanations on the following page.

PPO Experience Report Field Explanations

The Experience Report lists the following details on a claim by claim basis:

No.	Name	Explanation
1	**Last Name**	Last name of member.
2	**FI**	Member's first initial.
3	**Provider Patient Number**	Identification number assigned by provider.
4	**Sub No.**	Blue Cross member ID
5	**Group No.**	Member's BCBS group number.
6	**Admit Date**	Date of admission.
7	**Disch Date**	Date of discharge.
8	**Cases**	Each claim is listed as 1 case.
9	**Total Days**	The number of days paid on this claim.
10	**Med Surg Days**	Number of days not classified as ICU, Psych, SubAb, or Rehab.
11	**ICU Days**	Number of days paid for intensive level of care. Revenue Codes 174, 200-219.
12	**Psy Days**	Number of days paid for psych services.
13	**Sub Abuse Days**	Number of days paid for services related to substance abuse.
14	**Type**	A brief general description of the contract terms under which the service was discounted.
15	**Primary ICD-9 Proccd**	Industry defined claim level code that identifies the primary medical services performed.
16	**DRG IP** **CPT OP**	DRG value for inpatient claims, HCPCS code for outpatient medical claims.
17	**Serv Units**	If CPT fee schedule applies and claim is outpatient, then units of service provided.
18	**Covered Charges**	Amount billed by provider.
19	**Total Other Pmts Applied**	Any other charge for which the member is liable, i.e., deductible and coinsurance, coordination of benefits, non-covered charges
20	**Net Cov Charges**	Net payment calculated before discount; covered charges less member share and other payments applied.
21	**PPO Payment**	The contracted payment which varies for different provider types; each facility must refer to the terms of their specific contract.
22	**PPO Allowance**	The difference between the contracted payment and the total covered Blue Cross charges is the contractual allowance due to Blue Cross.

Sample HMO Experience Report

HMO ILLINOIS
HMOI EXPERIENCE REPORT

ABC HOSPITAL
HOSPITAL NO. 77

FOR THE MONTH ENDED 2009/08/31
With Bonus Settlement for the Month Ended 2009/06/30

HMO DISCOUNT FLAG: Y

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15		16	17	18
I/P OR O/P	LAST NAME	SUBSCR NUMBER	HOSPITAL CLAIM NO.	GROUP NUMBER	ADMIT DATE	DISCH DATE	REIMBURSEMENT TYPE	CASES	ACCUM CASE COUNT	DAYS	PCT FLG	NET COVERED CHARGES	DEDUCT & COPAYS	COORD. OF BENEFITS	NONCOVERED CHARGES	BILLED CHARGES	HMO PAYMENT	HMO ALLOWANCE
I/P	ADAMS	00000000111111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	MED./SURG	1	00602	7		33,204.00	250.00	.00	.00	33,454.00	13,239.00	19,965.00
	ADAMS	00000000111111111	123456789	H12345	mm/dd/yy	mm/dd/yy	MED./SURG	1	00639	2		18,066.00	250.00	.00	.00	18,316.00	5,531.00	12,535.00
	BLACK	00000000111111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	OB CASE	1	00616	4		39,006.80	250.00	.00	.00	39,256.80	11,312.00	27,694.80
	BURNS	00000000111111111	123456789	H12345	mm/dd/yy	mm/dd/yy	ICU/MED.SRG.	0	00604	2		14,084.00	.00	.00	.00	14,084.00	9,240.00	4,844.00
	COLLINS	00000000111111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	ICU	1	00586	2		11,265.00	125.00	.00	12.00	11,402.00	9,115.00	2,150.00
	DAVIS	00000000111111111	123456789	H12345	mm/dd/yy	mm/dd/yy	NURSERY	0	00601	6		3,461.00	.00	.00	.00	3,461.00	4,572.00	-1,111.00
	DOE	00000000111111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	BOARDER BABT	0	00586	3		8,079.00	250.00	.00	.00	8,329.00	5,680.00	2,399.00
	ADKINS	00000000111111111	123456789	H12345	mm/dd/yy	mm/dd/yy	MED./SURG	1	00657	4		2,203.00	.00	.00	.00	2,203.00	2,286.00	-83.00
	ADAMS	00000000111111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	MED./SURG	0	00609	1		9,431.00	.00	.00	.00	9,431.00	7,585.00	1,846.00
	BROWN	00000000111111111	123456789	H12345	mm/dd/yy	mm/dd/yy	OB CASE	0	00646	0		14,722.00	.00	.00	.00	14,722.00	5,781.00	8,941.00
	COLLINS	00000000111111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	ICU/MED.SRG.	0	00652	2		13,818.00	.00	.00	102.00	13,920.00	1,927.00	11,891.00
	DAVIS	00000000111111111	123456789	H12345	mm/dd/yy	mm/dd/yy	ICU	1	00603	3		9,246.00	600.00	.00	.00	9,846.00	10,084.00	-838.00
	EVANS	00000000111111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	NURSERY	1	00646	0		39,684.00	.00	.00	.00	39,684.00	11,562.00	28,122.00
	OTOOLE	00000000111111111	123456789	H12345	mm/dd/yy	mm/dd/yy	BOARDER BABT	1	00578	1		-39,430.00	.00	.00	.00	-39,430.00	-11,562.00	-27,868.00

Refer to field explanations on the following page

HMO Experience Report Field Explanations

The Experience Report lists the following details on a claim by claim basis:

No.	Name	Explanation
1	**I/P OR O/P**	I/P = Inpatient O/P = Outpatient
2	**Last Name**	Last Name of member
3	**Susbcr Number**	Blue Cross Subscriber Number
4	**Hospital Claim No.**	Provider Patient Number. Identification number assigned by hospital which is unique for each patient outpatient episode or inpatient bill.
5	**Group Number**	Member's BCBS group number.
6	**Admit Date**	Date of admission.
7	**Disch Date**	Date of discharge.
8	**Reimbursement Type**	Identifies applicable reimbursement provsion (e.g., Med/Surg per diem or OB Case Rate). In the HMO Discount Flag "N" section, it identified the reason the claim is not being discounted (e.g, Medicare primary). In the outcome bonus section (HMO Discount Flag "B"), the value is Bonus Payment.
9	**Cases**	Identifies inpatient case. A value of +1 for positive claims and -1 for claim reversals. Normal Newborn takes the value of 0.
10	**Accum Case Count**	Ignore. This is a case counter used for internal Blue Cross purposes.
11	**Days**	The number of days paid on this claim.
12	**Pct Flg**	Identifies claims paid based on a percentage discount. PCT FLG = Y when paid based on a percentage discount.
13	**Net Covered Charges**	This is the amount that Blue Cross paid up front.
14	**Deduct & Copays**	Deductibles, Coinsurance and Co-Payments for which the member is liable.
15	**Coord of Benefits**	Coordination of Benefit Amounts
16	**Billed Charges**	Total Billed Charges on the Claim
17	**HMO Payment**	The contracted payment which varies for different provider types; each facility must refer to the terms of their specific contract.
18	**HMO Allowance**	The difference between the contracted payment and the total covered Blue Cross charges is the contractual allowance due to Blue Cross.

Uniform Payment Program (UPP)

The **UPP** system of payment is a method of reimbursement designed to equalize payments to Blue Cross facilities. Blue Cross PPO facilities must demonstrate that they have an effective utilization program and will participate in cost containment activities. All Participating Provider Option (PPO) hospitals are on the UPP system. BCBSIL then provides an accelerated predictable, weekly payment that approximates an average week's worth of Blue Cross business. The advance is monitored on a weekly basis and adjusted as necessary. Over a period of time the advance should approximate claims processed, given the absence of disruption to normal performance goals for claim processing activities.

The purpose of the **UPP** is to provide a cash flow incentive to providers in consideration for having utilization review programs in place that favorably impact on admissions and length of stays of Blue Cross subscribers and also to facilitate the collection of contractual allowances.

Providers participating in the UPP receive:

- **An advance weekly check**
  UPP checks are produced every Wednesday evening (with a Friday date) and are ready to be picked up, mailed or sent via EFT to the provider's bank account. Thus, the provider has an advance that is expected to approximate the claims that will be processed during that week. *See the example on the following page for details on how the amount of the advance is calculated each week.*

- **Non-payment vouchers (PCS) without a check attached**
  As non-payment vouchers are received, the provider credits the subscriber's ledger and a corresponding debit is posted to their advance account. It is the provider's responsibility to maintain this daily log of non-payment vouchers so that the voucher numbers and amounts can be matched against the information reported on the UPP monthly summary.

- A monthly UPP Statement listing details (vouchers, advances, credits, and weekly/monthly balances) of the month's activity.

- Those providers receiving EFT will receive an electronic UPP check break down (report #0500) via their assigned protocol, EMCNET or NDM.

Calculations for Weekly UPP Check

Each provider's balance and advance amount are reviewed on a weekly basis. Adjustments to the advance are generally made when the provider's account balance falls outside the targeted range of a high of 5 days of business and a low equivalent to + 3.5 days of business (70-100% of average weekly claims processed).

Gross advance amount determining factors:

- Current UPP balance
- Average weekly claims processed (based on the previous 3 months of activity)
- Previous week's advance

Generally, if a provider's balance falls below the targeted range, the advances are increased until the target is achieved. **The increased gross amount is calculated as follows:**

Average claims processed times 1.7 less the current balance. For example:

- Weekly average claims processed $10,000
- Current UPP balance $ 4,000
- Previous week's UPP advance $10,000
- New advance amount $13,000

If the balance exceeds average claims processed by less than 20%, the advance is decreased until the balance is brought back in line. **The decreased gross amount is calculated as follows:**

Average claims processed times 2 less the current balance. For example:

- Weekly average claims processed $10,000
- Current UPP balance $11,000
- Previous week's UPP advance $10,000
- New advance amount $ 9,000

If the balance exceeds average claims processed by more than 20%, the advance is decreased until the balance is brought back in line. **The decreased gross amount is calculated as follows:**

Average claims processed times 2.2 less the current balance. For example:

- Weekly average claims processed $10,000
- Current UPP balance $15,000
- Previous week's UPP advance $10,000
- New advance amount $ 7,000

Once the balance is back in the targeted range, the advance amount will be set at the weekly average as follows:

Weekly average claims processed	$10,000
Current UPP balance	$ 9,000
Previous week's UPP advance	$ 8,000
New advance amount	$10,000

All calculations will be adjusted for the Processing Factor as necessary.

Posting Example

A patient's account is $5,000 and they have a comprehensive 100% contract.

Gross UPP amount	$5,000
Incentive contractual allowance	$1,000
HMO contractual allowance	$ 500
Net UPP amount	$3,500

The posting would be:

To record the receipt of the weekly UPP check
To post the receipt of the UPP voucher.

UPP Clearing Account	Incentive Contractual Allowance
5,000 (a)	1,500 (a)
5,000 (b)	

Cash Account
3,500 (a)

Patient's Ledger
5,000 (b)

Uniform Payment Program (UPP) Monthly Statement

UNIFORM PAYMENT PLAN
MONTHLY STATEMENT

PAGE 1
1 CNT# 80

2 ABC FACILITY
123 MAIN STREET
ANYTOWN, IL 60000
ATTENTION: CONTROLLER

3 CURRENT WEEKLY ADVANCE		4 BALANCE FROM	5 TOTAL ADVANCES	6 TOTAL CLAIM	7 MONTH END
AMOUNT	EFFECTIVE DATE	PREVIOUS MONTH	THIS MONTH	OFFSET THIS MONTH	BALANCE
290,700.00	00-00-00	68,160.38	1,090,900.00	920,181.28	238,879.10

DETAIL OF THIS MONTH'S ACTIVITY

8 DATE	9 DAILY UPP VOUCHER NUMBER	10 UPP ADVANCES	11 CLAIMS OFFSET	12 WEEK END BALANCE
01 03 01	03115003		41,575.52	
01 03 01	03290003		12,558.40	
01 04 01	03110004		18,032.08	
01 04 01	03286004		722.00	
01 05 01	03114005		6,294.90	
01 05 01	03284005		6,669.75	
01 06 01	03112006		37,833.04	
01 06 01	03287006		8,567.25	
01 07 01	03107007		18,893.93	
01 07 01	21935344	327,200.00		244,213.51
01 14 01	00140007		70.00	
01 14 01	03116014		23,250.40	
01 14 01	03294014		7,258.95	
01 13 01	03120013		14,041.60	
01 13 01	03304013		9,195.50	
01 12 01	03115012		26,204.76	
01 12 01	03295012		26,232.50	
01 11 01	00110007		72.00	
01 11 01	03118011		16,280.29	
01 25 01	03117025		34,485.60	
01 26 01	03120026		39,952.66	
01 26 01	03282026		13,317.50	
01 27 01	03115027		69,297.23	
01 27 01	03282027		13,655.25	
01 28 01	00280003		676.00	
01 28 01	03121028		6,449.93	
01 28 01	22222045	290,700.00		287,558.85
01 20 01	02092362		37.60	-
01 20 01	02093215		4,852.00	-
01 20 01	02093217		557.00	-
01 18 01	02173062		33.00	-
01 31 01	03124031		33,820.35	
01 3101	03302031		20,339.00	
	13 TOTALS	1,090,900.00	920,181.28	

	AVERAGE WEEKLY OFFSETS 3 MONTHS PERIOD ENDING 01-31-03	265,692.50
14	AVERAGE WEEKLY OFFSETS 6 MONTHS PERIOD ENDING 01-31-03	278,261.72
	AVERAGE WEEKLY OFFSETS 12 MONTHS PERIOD ENDING 01-31-03	262,983.33

UPP Monthly Statement Field Descriptions

No.	Field Name	Description
1	**Control Number (CNT #)**	The number assigned for this statement.
2	**Facility or Vendor Name & Address**	The facility or vendor who rendered the service(s).
3	**Current Weekly Advance** **Amount** **Effective Date**	Advance payment. Net of contractual allowance or adjustments. The amount advanced for the week. The date (Friday) for the check advance.
4	**Balance From Previous Month**	The difference between the UPP advance and offsets (remittances) as of end of previous month.
5	**Total Advances This Month**	The total amount advanced for the month.
6	**Total Claim Offset This Month**	The sum of remittances and refunds to Blue Cross for the month.
7	**Month End Balance**	The Month End Balance is the Beginning Balance plus Advances minus Offsets.
8	**Date**	The date the daily voucher was issued.
9	**Daily UPP Voucher Number**	The daily non-payment voucher number and or BC 370 number.
10	**UPP Advances**	Weekly advance checks.
11	**Claims Offset**	Remittance Advice or BC 370.
12	**Week End Balance**	UPP advance plus or minus claim offsets.
13	**Totals**	Total UPP advance plus or minus claim offsets.
14	**Average Weekly Offsets**	Average weekly offsets (remittance and BC-370 amounts) used to calculate future UPP payments.

Maximum Reimbursable Cost (MRC)

All Blue Cross facilities have a plan contract. Most hospitals have a MRC contract, which is a cost plus 5 percent payment system that is adjusted based on the annual cost report. Facilities are then contracted as necessary for other types of programs, e.g., PPO, HMO (HMO Illinois and BlueAdvantage HMO) and Blue*Choice*.

Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA)

For information on EFT/ERA and how to get started:

- Visit the E-Solutions section of this manual
- Contact the E-Commerce Center at (800) 746-4614, or
- Visit our Web site at: http://www.bcbsil.com/provider/ec/eft.htm.

Voucher Request

TO: **Blue Cross and Blue Shield of Illinois**
RSR Unit
5001 Meadowland Parkway
Marion, Illinois 62959

FROM:

Attention: _____

Hospital Name: _____

Hospital Address: _____

_____

NPI Number: _____

Check or Voucher Number: _____

Date of Issue: _____

Amount: _____

If Available:

Patient Group and ID Number: _____

Member Name: _____

Claim Number: _____

Is the Entire Voucher Needed or Only the information for this patient?

When requesting a copy of an UPP Voucher, please attach a copy of the UPP Monthly Statement.

This form is for vouchers, NOT check research.

6/08

Adjustments for Blue Cross Facility Claims

Late Charges and Corrected Claims

Late Charges are charges that were not included in the original billing. All late charges and credits must be filed within 90 days of the original claim payment.

- Late charges should be submitted electronically in the UB-04 format. (Blue Cross no longer uses forms BC55 or BC177 to submit late charges.)
- Submit **Type of Bill (TOB) X15 or X35**

Corrected Claims are submitted to correct the original claim.

- Submit **TOB X17 or X37** to replace a claim which include additional charges that were not included in the original claims

The following message will appear on your paper Provider Claims Summary (PCS) when late charges, corrected or replacement claims are submitted:

"This claim is denied. When a late charge or corrected claim is received for a service after the original claim has been finalized, any corrections, additions or adjustments are made to the original claims. No additional payment can be made until that review has been completed. You will be informed of the results of that review."

The following message will appear on your Electronic Provider Claims Summary (EPS) when late charges, corrected or replacement claims are submitted:

"The related ANSI Reason code 129 will appear on the ERA"

If a Late Charge or Corrected Claim is submitted and we have no original claim on file, that claim will be processed as if it were the original claim.

Your PCS message will state:

"This Late Charge/Corrected claim has been processed as a new claim. The original was not received."

Your EPS message will state

"The related ANSI Reason Code B13 will appear on the Electronic Remittance Advice (ERA)"

Professional Providers

Claim Filing: CMS-1500

Professional providers filing claims with BCBSIL must use the **CMS-1500** (version 08/05). For assistance with filling out the CMS-1500 (08/05) claim form, please refer to the CMS-1500 User Guide located on our provider Web site at www.bcbsil.com/provider. If you do not have the CMS-1500 (08/05) form, contact your print vendor to request a correct batch of paper claim forms. The form also may be ordered online at **http://bookstore.gpo.gov** or by calling **(202) 512-1800**.

Participating providers must bill all professional services using the CMS-1500 (08/05) format, either electronically or on paper, and

- May collect any copayment at the time of service.
- Should bill BCBSIL prior to collecting any fees from the patient. After receiving the Provider Claim Summary (PCS) or Electronic Remittance Advice (ERA), providers may bill the member for any applicable deductibles, coinsurance or non-covered services.
- May not balance bill the patient for any fees over the allowable charge.

For information on Electronic Media Claims, the EMC Options and how to get started billing electronically, contact our E-Commerce Center at (800) 746-4614, or visit our Web site at: http://www.bcbsil.com/provider/ec/edi_transactions.htm.

Claim Submission

Professional providers should submit claims electronically to BCBSIL for all members including those from other BCBS Plans.

Paper claims should be sent to:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

Reimbursement

Participating Providers

- BCBSIL will pay participating providers directly for all covered services.
- Payment for participating providers is based on the member's policy and the provider's contract participation:
  - Member policy with no Blue Shield provider network - U&C allowance
  - Member policy with PPO provider network - SMA amount
  - Member policy with Blue*Choice* network - SMA with Blue*Choice* tier system
- Providers receive a Provider Claim Summary (PCS) or Electronic Remittance Advice (ERA) that indicates the amount of payment, covered services, non-covered services, deductible and coinsurance or claim disposition.

Our Participating Provider Agreements now include the following statements that emphasize the importance of participating in electronic transactions have been inserted in the Billing and Reimbursement section, Article IV, Section 2:

"The PPO Plus Provider agrees to use his/her best efforts to participate with the Plan's Electronic Funds Transfer (EFT) under the terms and conditions set forth on the Electronic Funds Transfer Agreement. The PPO Plus Provider also agrees to use his/her best efforts to participate with the Plan's Electronic Remittance Advice (ERA) as described on the Electronic Remittance Advice (ERA) Enrollment Form."

Please note: This new contract language is for providers signing new agreements only. It is not an amendment to the current provider agreements in place.

Schedule of Maximum Allowances (SMA)

The SMA is based on a payment methodology called the Resource Based Relative Value Scale (RBRVS).

RBRVS has three main components:

1. Relative Value Units that are weights assigned for specific services based on:
   - Work: The physician's resources, including time and effort intensity
   - Overhead/practice expenses: Rent, salaries, equipment, supplies, etc.
   - Liability/malpractice insurance expenses

2. Geographic Practice Cost Index (GPCI)
   - Cost factors that reflect varying costs in different areas
   - A separate GPCI is applied to the RVU factors (work, overhead, liability) in each location

3. Conversion Factor
   - A number that converts relative weights created by RVUs and GPCIs for each procedure code into payment dollars. The weights are multiplied by the conversion factor to obtain the payment.

RBRVS Payment Formula

(Work RVU x Work GPCI) + (Overhead RVU x Overhead GPCI)
+ (Liability RVU x Liability GPCI) x Conversion Factor = Payment Allowed

Usual and Customary (U&C)

The **Usual** fee is the fee usually charged for a given service by an individual provider to private patients. A fee is **Customary** when it is within the range of **Usual** fees charged by providers of similar training and experience within a similar geographic area.

BlueChoice

Reimbursement is based on fee-for-service in accordance with the Blue*Choice* SMA. Additionally, PCP/PSPs are assigned a payment tier based on the following criteria:

- Quality Indicators
- Cost Efficiency

Performance Category (Payment Tier)	Description of Performance
Blue	Performance significantly higher than Blue*Choice* network norms.
White	Performance consistent with Blue*Choice* network norms.

Non-Participating Providers

Blue Shield will pay the member for covered services provided by non-participating solicitable providers. (Payment is based on the U&C allowance or the SMA as specified in the member's policy).

BCBSIL HMO

Contracted Medical Groups and IPAs are paid a monthly capitation fee for all HMO members enrolled with their group. The following chart outlines the reimbursement responsibility for the IPA and the HMO.

HMO Responsibility	IPA Responsibility
▪ Facility charges for: -Inpatient stays -Outpatient surgery -Out of area (NGA services) -Emergency Room visit ▪ Observation Units ▪ Professional Emergency Admission - Charges prior to IPA notification ▪ Professional charges for out of area emergency room visits ▪ Hospice ▪ Skilled Nursing Facility ▪ All charges for: -Extraction of fully bony impacted teeth -Voluntary Sterilization -Organ Transplants (approved by HMO) ▪ Prescription Drugs ▪ Vision Exam/Eyewear ▪ Chemical Dependency (If referred to HMO Network Provider) ▪ Durable Medical Equipment (If referred to HMO Network Provider) ▪ Skilled Home Health (If referred to HMO Network Provider) ▪ Outpatient dialysis (if referred to HMO network provider) ▪ Orthotics/Prosthetics (O&P) (If referred to HMO Network Provider. Note: Some O&P items are always IPA risk. Contact IPA for more details.) ▪ Medical Supplies (not from an MD office) ▪ Ground Ambulance ▪ ART/Infertility (If referred to HMO Network Provider)	▪ Professional Fees for: -Inpatient -Outpatient -In area Emergency Room visit ▪ Outpatient Diagnostics ▪ Outpatient Rehabilitation ▪ Medical Supplies from MD office ▪ Injections ▪ Immunizations ▪ Well Child Care ▪ Outpatient Mental Health ▪ Periodic Health Exams ▪ Dental - see Section II, C.2 of MSA ▪ Orthotics/Prosthetics (O&P) (If referred to Provider other than HMO Network Provider. Note: Some O&P items are always IPA risk. Contact IPA for more details.) ▪ Outpatient Radiation and Chemotherapy ▪ Outpatient Inhalation (Respiratory) Therapy ▪ Outpatient Hearing Screening ▪ Outpatient Ancillary Services ▪ Outpatient treatment ▪ Outpatient dialysis (if referred to provider other than HMO network provider) ▪ Day Rehabilitation ▪ ART/Infertility (If referred to Provider other than HMO Network Provider) ▪ Durable Medical Equipment (if referred to Provider other than HMO Network Provider) ▪ Skilled Home Health (if referred to Provider other than HMO Network Provider or for an Ambulatory member) ▪ Chemical Dependency Professional Charges (if referred to Provider other than HMO Network Provider)

Note: This list is not all inclusive.

Indemnity

Indemnity certificates provide specific allowances for covered services from a fixed schedule of benefits. The amounts of indemnity are not intended in any way to fix the value of the physician's service or to relate to such value.

Physicians are asked to charge their usual fees for services rendered to patients with indemnity coverage. The patient is responsible for any difference between the physician's charge and the indemnity allowance.

Copayments

Some PPO contracts have copayments for office visits and emergency room visits. Copayments may be listed on the member's ID card; however, some employer groups choose not to show the copayment on the ID card. **The copayment amount can always be determined by using one of our electronic options (Availity, NDAS Online or RealMed), or by calling the Interactive Voice Response System (IVR) at (800) 972-8088.**

Deductibles and Coinsurance

Deductibles and coinsurance vary by contract. This information can be obtained electronically or through the IVR. However, PPO and Blue*Choice* professional providers may not bill covered persons for deductible and coinsurance amounts prior to billing BCBSIL.

Reporting

PPO Provider Claim Summary

The Provider Claim Summary (PCS) is a notification statement sent to Blue Shield providers after the processing of a claim has been completed.

There are many different Provider Claim Summaries. The content of each summary varies based upon the member's benefit plan and the services provided.

The PCS Shows:

- Informational messages
- Level of benefits paid
- Amount paid
- Ad
  mount of the bill that is the patient's share

The Patient's Share May Include:

- Any portion of the billed amount that is not covered
- The patient's deductible/copayment amounts
- PPO program deduction

The sample Provider Claim Summary on the following page should be used as a **reference only.** Your summary may be different than the sample.

Call our Interactive Voice Response (IVR) System at (800) 972-8088 to inquire about patient membership, benefits, and claim status information.

Providers may also sign up to receive the Electronic Remittance Advice (ERA). The ERA is an electronic file that contains claim payment and remittance information, such as which claims were paid, the amount of each paym,ent andn the status of the claims that were processed. When providers enroll for the ERA, they will automatically receive the Electronic Payment Summary (EPS), which is an electronic print image of the PCS.

To obtain more information on the ERA, EPS, as well as Electronic Funds Transfer (EFT), contact the E-Commerce Department at (800) 746-4614 or visit our Web site at: http://www.bcbsil.com/provider/ec/eft.htm.

PPO Provider Claim Summary Example

(see Field Explanations on next page.)

BlueCross BlueShield of Illinois

A Member of the Blue Cross and Blue Shield Association
An Association of Independent Blue Cross and Blue Shield Plans

300 East Randolph Street
Chicago, Illinois 60601-5099

DATE: MM/DD/YY (1)
PROVIDER NUMBER: 0001112222 (2)
VOUCHER NUMBER: 123456789 (3)
TAX IDENTIFICATION NUMBER: 987654321 (4)

(5) **ABC MEDICAL GROUP**
123 MAIN STREET
ANYTOWN, IL 60000

PROVIDER CLAIM SUMMARY

ANY MESSAGES WILL APPEAR ON PAGE 1

(6) PATIENT: JOHN DOE
(7) AGE: 67
(8) CLAIM NO: 0000611112222344C
(9) IDENTIFICATION NO: P06666-XOC123456789
(10) PATIENT NO: 001001

(11) BEGIN DATE	(12) END DATE	(13) TS*	(14) PS **	(15) AMOUNT BILLED	(16) AMOUNT PAID	(17) OVER**** MAX ALLOW	(18) DEDUCTIONS/OTHER INELIGIBLE	(19) SERVICES NOT COVERED
01/01/00	01/01/00	006	01	80.00	50.00	11.00	19.00 (1)	0.00
				80.00	50.00	11.00	19.00	0.00

(20) AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $50.00

DEDUCTIONS/OTHER INELIGIBLE

(21) CONTRACT DEDUCTIBLE: 19.00
(22) DEDUCTIONS/OTHER INELIGIBLE: $19.00
(23) PATIENT'S SHARE: $19.00

**** YOUR SUBMITTED CHARGE EXCEEDS THE MAXIMUM ALLOWANCE. AS A PARTICIPATING PHYSICIAN, YOU HAVE AGREED TO ACCEPT THIS PAYMENT IN FULL AND NOT BILL OUR MEMBER FOR THE AMOUNT EXCEEDING THE MAXIMUM ALLOWANCE.

(24)

	$80.00	AMOUNT OVER U & C:	$0.00
AMOUNT PAID TO PROVIDER:	$50.00	AMOUNT OF SERVICES NOT COVERED:	$19.00
AMOUNT PAID TO MEMBER:	$0.00	AMOUNT PREVIOUSLY PAID:	
NUMBER OF CLAIMS:	1	AMOUNT OVER MAXIMUM ALLOWANCE:	$11.00

(25) *TYPE OF SERVICE (TS)
006. MEDICAL.

(26) **PLACE OF SERVICE (PS)
01. HOSPITAL INPATIENT.

(27) MESSAGES:
(1). A CONTRACT DEDUCTIBLE HAS BEEN TAKEN.

143 THIS IS THE NEW BLUE CHIP PCS 1 OF 1 THIS IS THE LAST PAGE OF THIS DOCUMENT

Health Care Service Corporation, A Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)

PPO Provider Claim Summary Field Explanations

1	**Date**	Date the summary was finalized
2	**Provider Number**	The physician's National Provider Identifier number
3	**Voucher Number**	The number assigned to the check for this summary
4	**Tax Identification Number**	The number which identifies your taxable income
5	**Provider or Group Name & Address**	The provider/group address who rendered the services
6	**Patient**	The name of the individual who received the service
7	**Age**	Patient's age
8	**Claim Number**	The Blue Shield number assigned to the claim
9	**Identification Number**	The number which identifies the group and Member insured by BCBSIL
10	**Patient Number**	The patient's account number assigned by the provider
11 **12**	**Begin Date/End Date**	Indicates the beginning and ending dates of services rendered
13	**TS**	Type of service
14	**PS**	Place of service
15	**Amount Billed**	The amount billed for each procedure/service
16	**Amount Paid**	The amount paid for each procedure/service
17	**Over Max Allow**	The amount exceeding the schedule of maximum allowances for the Plan. The patient is not responsible for this amount. This is the provider's write-off
18	**Deductions/Other Ineligible**	Program deductions, copayments and coinsurance amounts
19	**Services not covered**	Non-covered services according to the members contract
20	**Amount paid to provider for this claim**	The amount Blue Shield paid to provider for this claim
21	**Contract Deductible**	The deductible amount applied to this claim (patient's responsibility)
22	**Deductions/Other Ineligible**	Same as field 18
23	**Patient's Share**	Amount patient pays. Providers may bill this amount to the patient
24	**Claim Summary Section Totals**	This section indicates how this claim was adjudicated
25	**Type of Service (TS)**	The description for the type of service code used in field 13
26	**Place of Service (PS)**	The description for the place of service code used in field 14
27	**Messages**	The description for messages relating to: ■ Non-covered services ■ Program deductions ■ PPO reductions

Note: Not all Provider Claim Summaries are the same. This PCS is provided as a sample. The format and content of this PCS is based upon the member's PPO benefit plan and service.

Refunds/Payment Recovery Program

The Payment Recovery Program (PRP) allows us to recoup overpayments made to BCBSIL contracting facilities and providers in the PPO, Blue*Choice* Select and HMO product networks when payment errors have occurred. Overpayments can occur as a result of duplicate payments, non-covered services, COB, etc.

Refund Process

When an overpayment is identified by BCBSIL, we follow this process:

1. A refund request letter is sent to the payee which explains the reason for the refund, and includes a remittance form and return address envelope.
2. If we do not receive a response to our initial letter, a follow up letter is sent asking for payment.
3. If we do not hear from you by telephone or in writing or you do not return the amount of the overpayment within 30 days from the date of the follow up letter BCBSIL will recover the overpayment by offsetting current claims payments by the amount due to us.
4. The patient information and recovery amount are explained on the Provider Claims Summary (PCS), the Electronic Remittance Advice (ERA) version (ANSI 8354010A1), and UPP Monthly Statement, when applicable.

The PCS will display:

- The total amount recouped toward the overpayments
- The net amount after recoupment has been applied
- Information regarding the specific overpaid patient account (i.e., patient name, patient account number, service dates, etc.), the amount of overpayment recouped and the overpayment reason

The ERA will display:

- Information in a PLB segment when an overpayment is recovered by BCBSIL. The ANSI 835 4010A1 will be displayed as follows:
    - PLB*123456978*20041231*WO:0000123456789X*25.30~
    - PLB01 = Provider Identifier (Provider #)
    - PLB02 = Fiscal Period (CCYYMMDD)
    - PLB03-01 = Adjustment Identifier (WO = Overpayment Recovery)
    - PLB03-02 = Provider Adjustment Identifier = DCN # will be provided
    - PLB04 = Provider Adjustment Amount

- Providers receiving old ERA formats NSF, ANSI 3030 and 3051 will have to check the Provider Claim Summary (PCS/EPS) reports to verify overpayment information.

The UPP Monthly Statement will display:

- A separate line for recoupment amounts (with corresponding voucher number on the PCS) if refund is not received

Submitting a Refund

Mail
\We will accept the BC370 Form for processing of manual refunds. See pages 34-35 for instructions on how to complete the Provider Refund Form.

Online
UPP and non-UPP providers can now electronically submit refunds to BCBSIL using the Electronic Refund Management (ERM) tool. (See page 35). The refunds are applied real-time, eliminating the need to mail in a BC-370 form.

Refunds are submitted for the following reasons only:

C.O.B. Credit	Payment has been received under two different Blue Cross numbers, or from Blue Cross and another carrier. Indicate name, address and amount paid by other carrier.
Overpayment	Blue Cross payment in excess of amount billed; provider has posted a credit for supplies or services not rendered; or provider canceled charge for any reason.
Duplicate Payment	A duplicate payment has been received from Blue Cross under the same group and subscriber number
Not Our Patient	Payment has been received for a patient that did not receive services from you.
Medicare Eligible	Payment for the same service has been received from Blue Cross and the Medicare intermediary.
Workers' Compensation	Payment for the same service has been received from Blue Cross and a Worker's Compensation carrier.

The Recovery of Overpayments Due BCBSIL policy is located in the Health Care Management Administrative Policy and Procedure section of the BCBSIL Provider Manual.

Provider Refund Form Instructions

Refunds Due to Blue Cross Blue Shield

1) Key Points to check when completing this form:

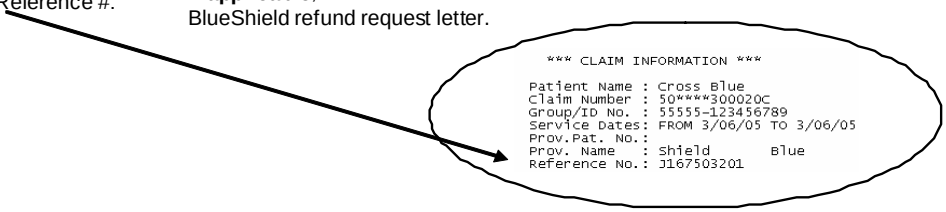
a) Group/Member Number: Indicate the number exactly as they appear on the PCS (Provider Claim Summary) - including group and member's identification number

b) Admission Date: Indicate the admission or outpatient service date as MMDDYY entry.

c) BCBS Claim/DCN #: Indicate the BlueCross BlueShield Claim/DCN number as it appears on the PCS/EOB. Please do not use your provider patient number in this field.

d) Provider Patient #: Indicate the Patient account number assigned by your office.

e) Letter Reference #: **If applicable**, indicate the RFCR letter reference number located in the BlueCross BlueShield refund request letter.



f) Check Number and Date: Indicate the check number and date you are remitting for this refund.

g) Amount: Enter the total amount refunded to BlueCross BlueShield.

h) Remarks/Reason: Indicate the reason as follows:

- "C.O.B. Credit"	Payment has been received under two different Blue Cross memberships or from Blue Cross and another carrier. Indicate name, address, and amount paid by other carrier.
- "Overpayment"	Blue Cross payment in excess of amount billed; provider has posted a credit for supplies or services not rendered; provider cancelled charge for any reason; or claim incorrectly paid per contract.
- "Duplicate Payment"	A duplicate payment has been received from BlueCross for one instance of service (e.g. same group and member number).
- "Not our Patient"	Payment has been received for a patient that did not receive services at this facility/treatment center.
- "Medicare Eligible Duplicate Payment"	Payment for the same service has been received from Blue Cross and the Medicare intermediary.
- "Workers Compensation"	Payment for the same service has been received from Blue Cross and a Workers' Compensation carrier.

2) Mail the refund form along with your check to:

Blue Cross and Blue Shield of Illinois
Cash Receipts Department
PO Box 805107
Chicago, IL 60680-4112

Rev 7/08

Sample Provider Refund Form

BlueCross BlueShield of Illinois

Provider Refund Form

Please submit refunds to:
Blue Cross and Blue Shield of Illinois
PO Box 805107, Chicago, IL, 60680-4112

Provider Information:

Name:

Address:

Contact Name:

Phone Number:

NPI Number:

Refund Information:

1	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
2	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
3	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
4	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
5	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			
6	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENTS NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			

SIGNATURE	DATE	CHECK NUMBER	CHECK DATE

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Electronic Refund Management (ERM)

ERM is an online refund management tool that features many practice enhancing components, which will help simplify overpayment reconciliation and related processes, and is available at no additional charge.

ERM offers the following features:

- **Single sign-on** - Current users of Availity® or RealMed®.* must complete an online on-boarding form to obtain access to ERM through one of these online portals.
- **Electronic notifications of overpayments** – You have the option to replace paper requests for claim refunds (RFCRs) you receive with a daily or weekly e-mail summarizing overpayment requests for each NPI. This helps reduce the cost of maintaining overpayment records.
- **Ability to settle your overpayment requests** – BCBSIL can deduct the overpayment from a future claim payment. Details will appear on your PCS or EPS. Information in your ERM transaction history can also assist with recoupment reconciliations.
- **Ability to inquire about, dispute or appeal** requests online – If you have any disagreements or if you would like more information for each request, your request can be submitted online.
- **View overpayment requests** – You can view and search/filter all new, outstanding, and closed refund requests that contain an NPI related to your office/facility. You can view more details for each request, including claim, patient account number, service dates, overpayment reason, etc. ERM gives you a real-time transactional history for each refund request, showing a complete audit trail for tracking when an action was taken on a particular item, and who performed it (including closed requests).
- **Pay by check** – You may select one or multiple requests and refund BCBSIL by sending us a check. You will be asked to include a system generated remittance form showing the detail of your refund (generated within ERM). When BCBSIL receives your refund check you will see the check number that you sent to settle your overpayment
- **Submit unsolicited refunds** – If you identify a credit balance, you can submit it online and refund your payment by check, or we can deduct the refund from a future claim payment You will still see the information on your PCS or EPS, and you can also see the details in the ERM transaction history to assist with all recoupment reconciliations. No other contact (e.g. phone inquiry) is necessary for the credit balance/overpayment situations.
- **System Alerts** – You will receive notification via the ERM system in certain situations, such as if BCBSIL has responded to your inquiry or if a claim check has been stopped.

There are two ways to register for ERM:

1. Visit the Availity Web site
2. Call RealMed Customer Service Center at (877) REALMED (732-5633)

How to Gain Access to ERM

How to Gain Access to eRM Prior to accessing eRM, you must be registered with Availity® or RealMed®.

For Availity registration information, visit www.availity.com, or call Availity Client Services at (800) AVAILITY (282-4548).

For RealMed registration information, visit www.realmed.com, or contact the RealMed Customer Service Center at (877) REALMED (732-5633).

Once you're registered, log on to complete the online onboarding form:

- **Availity Users** – Click on the HCSC Refund Management link under the Claims Management tab. If you are unable to access this link, please contact your Primary Access Administrator (PAA). If you do not know who your Primary Access Administrator is, click on Who controls my access? You may also contact Availity Client Services at (800) AVAILITY (282-4548) for assistance, or visit www.availity.com for more information.

- **RealMed Users** – Click on the HCSC Financial Management link under the Administration tab. If you are unable to access this link, consult with your RealMed Customer Account Manager, or contact the RealMed Client Support Center at (877) 927-8000.

Need more information?
Our support team is available to assist you! If you have any questions, or if you would like to attend an instructor-led eRM Webinar including a live demonstration of the system, send an e-mail to eRM@bcbsil.com.