BLUE CROSS AND BLUE SHIELD OF ILLINOIS
MEDICARE ADVANTAGE HMO POLICY

DEPARTMENT: IL Provider Performance Management	**PROCEDURE NUMBER:** GCS-IL-MA-10B	**ORIGINAL EFFECTIVE DATE (IF KNOWN):** 01/01/2013
PROCEDURE TITLE: Financial Risk Claims Procedure		**EFFECTIVE DATE:** 08/09/2022
		LAST REVISION DATE: 08/09/2022
EXECUTIVE OWNER: Executive Director, Provider Performance	**BUSINESS OWNER:** Manager, Provider Performance	**LAST REVIEW DATE:** 08/09/2022

I. SCOPE

This Procedure applies to Provider Performance Management government product Medicare Advantage HMO.

This Procedure applies to the following lines of business and products:

Line of Business / Product Scope / Plan Scope/Contract Number (if applicable)	In Scope [x]
Medicare MAPD H3822	X
NOTE: Future fully executed contracts will fall under this procedure.	

II. POLICIES IMPLEMENTED BY PROCEDURE

This Procedure implements the following Policies:

Financial Risk Claims Policy, GCS-IL-MA-10A. This procedures document ensures there is a documented process for Financial Risk Claims.

III. PROCEDURE

1. The claim will be submitted either electronically or on paper to BCBSIL for processing.

2. Once the claim is received it will be reviewed to determine if it was submitted with the approval status on the claim or if BCBSIL needs to reach out to the IPA to obtain approval status.
• If a paper claim is submitted with an approval stamp from the IPA, the claim will go through the normal claims processing channels.
• If the claim (electronic or paper) was submitted on a UB-04 and the claim has a value of 1

(Physician Referral) or 3 (HMO Referral) in the Source of Admission field (15) and "GAP" in the Treatment Authorization field (63), the BCBSIL claims processing system will read the online provider file to verify if the facility and IPA have an Expedited Approval Agreement (GAP) Agreement in place. The claim will be processed accordingly if all criteria are met.
• If it is determined that the facility and IPA do not have an Expedited Approval Agreement (GAP) agreement in place, the claim will be pended and be sent to the IPA via the internet 095 report to obtain approval status.

NOTE: BCBSIL will not automatically provide a copy of the claim, for which we are seeking approval status, to the IPAs. The IPAs can contact BCBSIL to request a copy of the claim if they need the claim to determine approval status.

3. The IPA is required to respond within 10 calendar days to the 095 Report by checking the appropriate box for each claim listed. All responses must be received prior to 7:59 p.m. on the 10th calendar day.

4. Guidelines for determining group approval status on the 095 Report:
a. [ ] GA – Group Approved Claim is group approved, services were rendered by or referred by a Primary Care Physician (PCP) or Participating Specialist Provider (PSP) affiliated with the IPA.
b. [ ] NGA - Not Group Approved Claim is not group approved, member was not treated by or referred by a PCP or PSP affiliated with the IPA.
c. [ ] MGR - Med Group Risk Claim is group approved and is the financial risk of BCBSIL but the IPA has made the determination to assume the responsibility to pay the provider, then the following rules apply:

1. The IPA must pay according to the rules of Prompt Pay legislation.
2. If a member calls BCBSIL after 45 days from the response to the 095 Report stating the claim remains unpaid, BCBSIL will contact the provider. If the bill is unpaid, BCBSIL will pay the claim.

d. If an IPA risk claim appears on the 095 Report, check GA or NGA and in the comment, field indicate the claim is IPA risk.
e. Partial Group Approved – PGA – If the IPA is notified of an in-patient admission, the IPA indicates 'PGA 'from the point of notification of the in area in-patient admission.

5. If the IPA fails to respond to the 095 report by 7:59 pm on the 10th calendar day, the claims will default to a status of Group Approved and BCBSIL will process the outstanding claims.
a. All claims related to that date of service that are the IPA's financial risk will also default to Group approved status and the IPA will be required to pay all related services.

6. If the IPA submits an incorrect approval status (whether via an 095 response or a stamped paper claim) and changes the status from group-approved to non-group approved, the IPA must send their request to change the status within five calendar days of the original submission.

IV. CONTROLS/MONITORING

Control Document or Control Description	Control Owner
Annual review of delegated IPA Policy and Procedure	Manager, Illinois Provider Performance

V. AUTHORITY AND RESPONSIBILITY

- Lupita Monroy, (Manager, Illinois Provider Performance Management

VI. PROCEDURE REVIEWERS

Person Responsible for Review	Title	Date of Review
Lupita Monroy	Manager, Illinois Provider Performance Management	06/07/2022
Sandra Hopson	Provider Affairs Project Consultant	06/03/2022

VII. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
Annual Review: Controls/ Monitoring section update to match updated wording.	06/03/2022
Annual Review: New Template/ Procedure Section reformatted for better flow, no procedural changes.	03/26/2021

VIII. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
Medicare P&P Comm.			08/09/2022
IL Provider Performance Management	Joanne O'brien	Executive Director	06/08/2022
IL Provider Performance Management	Joanne O'brien	Executive Director	05/20/2021