

Blue Cross and Blue Shield of Illinois Provider Manual

HMO Claims Processing Section

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Claims Delegation Requirements and HMO Oversight

IPA agrees to accept the delegation for claims processing functions from the HMO for those services provided and determined to be the IPA's responsibility as outlined in the MSA. The IPA shall perform claims processing functions in accordance with state and federal laws, rules, and regulations, and regulatory or accreditation entities to whom the HMO is subject, and as required by the HMO. Delegation of claims processing is subject to the HMO's review and approval.

IPA shall allow the HMO, or its designee, to monitor the accuracy, quality, timeliness and effectiveness of IPA's claims adjudication and processing functions and activities through periodic reviews and audits. Upon request, IPA will provide the HMO, or its designee, access to all documents, processes, procedures, systems and other information related to claims processed, paid or denied by IPA. The following is a list of information that may be reviewed during an audit requested by the HMO. This list is not all-inclusive and may be modified by the HMO.

- The IPA's policies and procedures for claims adjudication
- Samples of claims payments, claims denials and pended claims.
- All source documentation supporting claims payment, denial, or pended claims.

HMO IPA Redirected Claims Process

IPA Redirected Claims Submissions

IPAs can:

1. Submit all HMO risk to the following address. All HMO risk claims must be stamped with approval status (GA, NGA)

PO Box 660603
Dallas, Texas 75266-0603

2. IPA – Redirected HMO (039) Claims Process
 - o Effective January 2023, IPAs can use the BCBSIL IPA Access portal to redirect IL HMO (039) claims. BCBSIL created a secure portal that allows IPAs to send PDF group approved and non-group approved claim copies through the BCBSIL IPA Access portal at <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>. This process can be used in lieu of mailing medical group risk and HMO risk claims to BCBSIL for processing. The new process enables BCBSIL to begin processing redirected claims more quickly and improves redirected claim tracking capabilities.
 - o **Using the Process**
 - All IPAs and approved contract management firms (CMFs) are eligible to use the IPA Portal to redirect claims to BCBSIL.
 - The process applies only to claims that IPAs need to redirect or return to BCBSIL.
 - IPAs can send unlimited daily claim batches (up to 100 pages per batch).

IPA Redirected Claims Retrieval

IPAs can:

1. Retrieve redirected claims via mail through the US Postal Service.
2. IPA – Redirected HMO (039) Claims Process
 - o Effective November 2023, IPAs can use the BCBSIL IPA Access portal to retrieve redirected IL HMO (039) claims. BCBSIL created a secure portal that allows IPAs to send PDF group approved and non-group approved claim copies through the BCBSIL IPA Access portal at <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>. This process can be used in lieu of retrieving mailed paper claims.
 - o **Using the Process**
 - All IPAs and approved contract management firms (CMFs) are eligible to use the IPA Portal to redirect claims to BCBSIL.
 - The process applies only to claims that BCBSIL need to redirect or return to the IPA.
 - Claims will be sent to IPAs daily.

For questions about the redirected claims process or the upload guide, please contact your assigned Provider Network Consultant.

Claim Processing Procedures

- All IPA responsibility claims should be submitted directly to the appropriate IPA for payment. All HMO responsibility claims should be submitted **electronically** to BCBSIL.
- The member's IPA will adjudicate claims received and offer the following dispositions:
 - o **Group Approved (GA)** – The service was managed by one of the IPA's physicians or referred by an IPA physician.
 - o **Non-Group Approved (NGA)** – The service was not managed by one of the IPA's physicians or referred by an IPA physician.

- If the HMO has a question regarding a claim, the HMO will contact the IPA. This will be done via telephone or by email. Each IPA has identified an email contact that will be used for this purpose. If the email is sent by the HMO before 2 p.m., a response is expected back from the IPA on the same day. If the email is sent after 2 p.m., the response is expected the next business day.

The following chart lists the services that are the financial responsibility of the HMO and the financial responsibility of the IPA.

HMO Responsibility	IPA Responsibility
<ul style="list-style-type: none"> ▪ Facility charges for: <ul style="list-style-type: none"> -Inpatient stays -Outpatient surgery -Out-of-area (NGA services) -Emergency room visit -Behavioral Health ▪ 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: <ul style="list-style-type: none"> -Extraction of completely bony impacted teeth -Voluntary Sterilization -Organ Transplants (approved by HMO) -Transgender Services (approved by HMO) ▪ Immunizations only for: <ul style="list-style-type: none"> -COVID-19 -Influenza -RSV (Adult/Pediatric) -Shingles ▪ Prescription Drugs ▪ Vision Exam/Eyewear ▪ 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) ▪ Ambulance Services ▪ ART/Infertility (If referred to HMO Network Provider) ▪ Outpatient Private Duty Nursing for Blue Precision HMO, BlueCare Direct 	<ul style="list-style-type: none"> ▪ Professional Fees for: <ul style="list-style-type: none"> -Inpatient -Outpatient -In-area Emergency Room visit -Behavioral Health, including Telepsychiatry for Blue Precision HMO, BlueCare Direct ▪ Outpatient Diagnostics ▪ Outpatient Rehabilitation ▪ Medical Supplies from MD office ▪ Injections ▪ Immunizations (excluding: COVID-19, Influenza, RSV (Adult/Pediatric) & Shingles) ▪ Well child care ▪ Periodic Health Exams ▪ Dental (Some dental related services, contact IPA for more details) ▪ 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)

Note: This list is not all inclusive.

Notice of Benefits and Payment Parameters (NBPP) DOFR Effective: 1/1/2023

The following chart is reflective of the specific services that are affected by NBPP. At this time, they are the financial responsibility of HMO.

HMO Responsibility	Notes
High Tech Imaging (CT, PET Scans, MRIs) *	Facility and Professional
Lab Services*	Facility and Professional
X-rays/Diagnostic Imaging*	Facility and Professional
Outpatient Surgery*	Facility and Professional

*Services Outpatient

If members are needing services other than those listed in the NBPP DOFR, please refer to the Division of Financial Responsibility (DOFR) on page 4 of this manual.

Listed below are the 12 impacted Blue Precision benefit plans that are HMO risk:

Please note: The context in the highlighted data fields below will update/change on an annual basis.

Benefit Plans Impacted	MPI	Group Number	Section Number	Plan Name	Scope Number	Plan Number
Blue Precision Gold HMO 707	GHSA47BAVILO	IG2301	0001	ATT30	38	X38
Blue Precision Gold HMO 707	GHSA47BAVILP	IG1301	0001	AUT30	38	Y38
Blue Precision Gold HMO 707	GH3A47BAVILP	IG1301	0003	AVT30	39	A39
Blue Precision Silver HMO 706	SHSA48BAVILO	IS2301	0001	AWT40	39	C39
Blue Precision Silver HMO 706	SHSA48BAVILP	IS1301	0001	AYT40	39	D39
Blue Precision Silver HMO 706	SH3A48BAVILP	IS1301	0003	BAT40	39	E39
Blue Precision Silver HMO 706	SH4A48BAVILP	IS1301	0004	AXT30	39	B39
Blue Precision Silver HMO 706	SH5A48BAVILP	IS1301	0005	AST20	38	W38
Blue Precision Silver HMO 706	SH6A48BAVILP	IS1301	0006	ART00	38	V38
Blue Precision Bronze HMO 708	BHSA82BAVILO	IB2302	0001	BBT50	39	F39
Blue Precision Bronze HMO 708	BHSA82BAVILP	IB1302	0001	BCT50	39	G39
Blue Precision Bronze HMO 708	BH3A82BAVILP	IB1302	0003	BDT50	39	H39

HMO Responsibility Claims

The HMO must determine Group Approval status on all HMO responsibility claims. There are three methods:

1. The HMO will receive the claim from the IPA stamped with the approval status. The claims should be stamped with the approved HMO stamp using **blue or black ink only**. (See below for sample IPA Approval Stamp). The IPA number, name, approval status, date and initials should be filled in. Claims should be sent to the PO Box referenced on page two of this section. Approved claims will then be processed according to the benefits of the contract. Appropriate units will be charged to the IPA's Utilization Management Fund. Non-group Approved claims will be denied and an Explanation of Benefits will be sent to the provider and member.

Sample IPA Approval Stamp

HMO IPA #	_____
Date Received (By IPA)	_____
GA	<input type="checkbox"/>
NGA	<input type="checkbox"/>
Date Returned	_____
Name or Initial	_____

2. Through the Automatic Group Approval Process (GAP), the IPA and a hospital must sign an Expedited Approval Agreement with the HMO. The IPA will provide group approval status to the hospital. The hospital will bill the HMO, with the group approval status noted on the claim form, and the claim will be processed accordingly.
3. The HMO will make available to the IPA the daily 095 report via the Blue Access for Providers website. This report can be accessed at https://providers.hcsc.net/providers/il_login.html. Each IPA user must have a secure sign on. If you do not have access to the portal, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf. If technical assistance is needed after the sign-on is received, contact the Help Desk at 312-653-6675 and ask for the Internet Help Desk for Blue Access for Providers assistance.

The IPA will indicate approval status for each claim listed on the report. (Refer to training materials in next section for process). The IPA's response must be made within 10 calendar days. The response must be submitted prior to 8 p.m. on the 10th calendar day. If the response is not received, the HMO will assume the claim is group-approved and pay accordingly. All units will be charged to the IPA and cannot be challenged. The related professional charges will also be considered approved and the IPA's responsibility to pay.

The IPA should download the data monthly for historical documentation purposes and to prepare for any future Utilization Management Fund Challenges. The HMO will not be able to produce historical reports for the IPA. The data definitions are located on the Internet site.

HMO Online (095) Claims Report Application

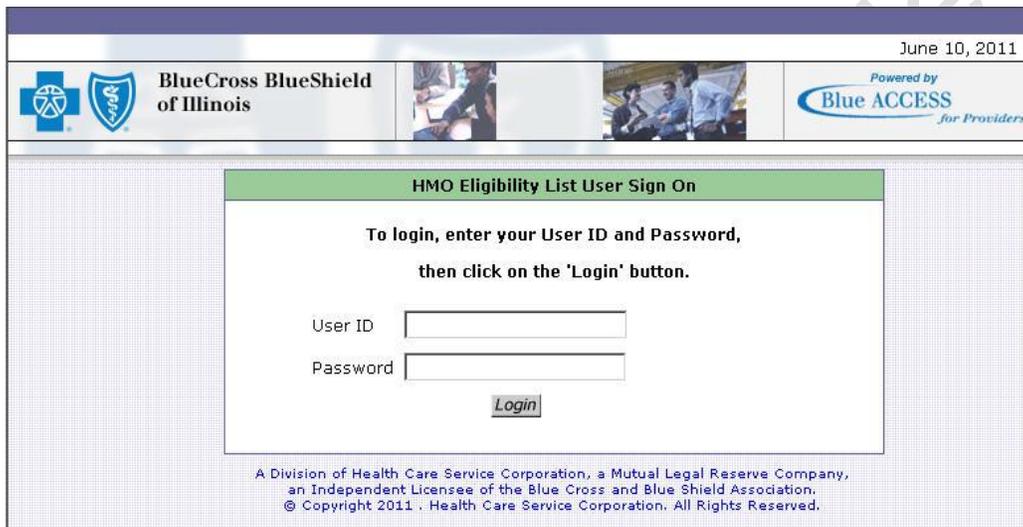
Assumptions

- User is currently logged on
- User has access to the IPA
- User has access to the claims reports.

HMO Online (095) Claims Report Application

The functionality of the HMO Claims Report includes the ability to view and respond with the group approval status of claims that are the financial risk of the HMO. Various reports may be downloaded, including open claims, closed claims and a data definition report. The following instructions provide step by step directions on how to use the application. Refer to the Troubleshooting Tips found in this section if additional assistance is needed.

1. The Login page will be displayed.



June 10, 2011

Blue Cross BlueShield of Illinois

Powered by Blue ACCESS for Providers

HMO Eligibility List User Sign On

To login, enter your User ID and Password,
then click on the 'Login' button.

User ID

Password

Login

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2. Enter your User ID in the User ID field in the body of the page.

User ID

3. Enter your password in the password field in the body of the page.

Password

4. Click on the 'Login' button once using

Login

5. Select the **HMO Claims Report** link.

6. Click on 095-Request for Group Approval Status List

HMO Claims

Choose the following reports to get more HMO Claim Information.

[095 - Request for Group Approval Status List](#)

7. Select an IPA, if you have access to more than one, in the drop down box.



8. You should arrive at this search window. You have multiple options to search for open or closed claims. If searching by Subscriber ID number, you need to use 12 digits. If the ID number has less than 12, add zero to the front to fill into the space – e.g., 000123456789. To see the entire report, you may click on display.

Blue Access for Provider - Blue Cross Blue Shield of Illinois - Microsoft Internet Explorer

Address: <http://providers.cal.fyblue.com/providers/servlet/com.hcsc.provider.hmoclaim.Hmo095ClaimListServlet?unique=UBO2GXNT3HCRFX1AXIEF11Y-1076703878491>

Blue Cross Blue Shield of Illinois

Powered by Blue ACCESS for Providers

Home > 095-Request for Group Approval Status Report

HMO Eligibility

- Eligibility List
- Changes Since Last Eligibility List
- New Members Address List

HMO Financial

- Capitation
- Reconciliation Report
- Capitation Summary Report
- Activity Counts
- Capitation by Benefit Plan
- Age and Gender Counts

HMO Claims

- 095 - Request for Group Approval Status List

095-Request for Group Approval Status Report

Medical Group: 500 - BLUE CROSS BLUE SHIELD CLINIC 500

[Download Data](#) [Data Definition](#)

Enter search field(s):

Report Date Range: [Dropdown]

-OR-

Specific Date Range: [MM/DD/YYYY] to [MM/DD/YYYY]

Approval Status: [Dropdown]

Subscriber ID: [Text Box]

Internal Reference Number: [Text Box]

Patient Last Name: [Text Box]

DCN Number: [Text Box]

Subscriber SSN: [Text Box]

Provider Name: [Text Box]

[Display](#) [Clear](#)

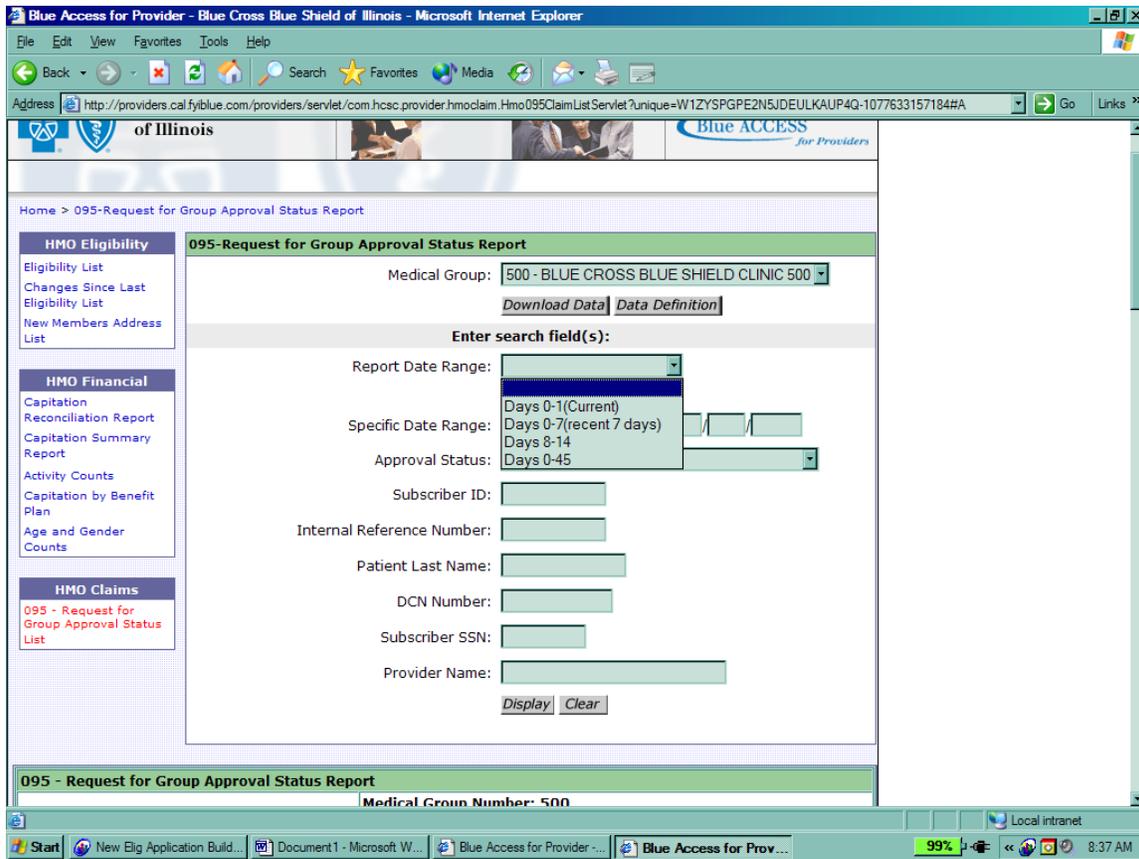
Blue Cross Blue Shield of Illinois and Blue Cross Blue Shield of Texas, Divisions of Health Care Service Corporation, a Mutual Legal Reserve

Done

Local intranet

Start | TrainingManu... | Re, new M & ... | Microsoft Exc... | 5 Internet ... | A - [24 x 80] | Microsoft Wor... | Microsoft Pow... | 100% | 2:25 PM

9. Alternatively, you may enter a search argument such as a 'Report Date Range' by clicking on the drop-down box in 'Report Date Range' and then click 'Display' to see the list.



10. You may also enter a search argument in the 'Approval Status' drop down, such as all open claims waiting for approval, OP. If no status is selected, all claims will be displayed when you click on the 'Display' button.

The screenshot shows a web browser window titled "Blue Access for Provider - Blue Cross Blue Shield of Illinois - Microsoft Internet Explorer". The address bar shows a URL: <http://providers.cal.fyblue.com/providers/servlet/com.hcsc.provider.hmoclaim.Hmo095ClaimListServlet?unique=W1ZYSPGPE2N5JDEULKAUP4Q-1077633157184#A>. The page content includes a navigation menu on the left with sections for "HMO Eligibility", "HMO Financial", and "HMO Claims". The main content area is titled "095-Request for Group Approval Status Report" and contains the following form fields:

- Medical Group: 500 - BLUE CROSS BLUE SHIELD CLINIC 500
- Buttons: [Download Data](#) [Data Definition](#)
- Section: Enter search field(s):
- Report Date Range: [Dropdown]
- OR-
- Specific Date Range: [Date] / [Date] / [Date] to [Date] / [Date] / [Date]
- Approval Status: [Dropdown]
- Subscriber ID: [Dropdown]
- Internal Reference Number: [Text]
- Patient Last Name: [Text]
- DCN Number: [Text]
- Subscriber SSN: [Text]
- Provider Name: [Text]
- Buttons: [Display](#) [Clear](#)

At the bottom of the form, there is a summary bar: "095 - Request for Group Approval Status Report" and "Medical Group Number: 500". The Windows taskbar at the bottom shows the Start button, several open applications, and the system tray with the time 8:40 AM.

11. Scroll down and the list or index report will appear. If all claims were selected as in the example, the status column will display the disposition of the claim. To view or provide an approval status, click the DCN number on the left column.

D95-Request for Group Approval Status Report										
							Medical Group Number: XYZ		NPI: Not Available	
							Medical Group Name: Health Partners			
							All Available Claims			
Row: 1 - 50 of 760										
#	DCN Number	Report Date	Patient Name	Subscriber ID	FromDate - ToDate	Prc Ind	Provider Name	Status	Sub SSN	Int Ref Nbr
3	111111111111	11/08/2011	Jane Doe	2222222222	10/15/2011 10/20/2011		ABC Medical Group	GA	111-22-3333	99351034
4	111111111111	11/08/2011	John Doe	2222222222	10/22/2011 10/31/2011		ABC Medical Group	GA	111-22-3333	
5	111111111111	11/08/2011	Jane Doe	2222222222	10/07/2011 10/07/2011	DM	HOME CARE PRODUCTS	GA	111-22-3333	
6	111111111111	11/08/2011	John Doe	2222222222	10/15/2011 10/20/2011		DIALYSIS CNTR	GA	111-22-3333	
7	111111111111	11/08/2011	Jane Doe	2222222222	10/28/2011 10/28/2011	OS	PARK SURGICAL CNTR LLC	GA	111-22-3333	99796661
8	111111111111	11/08/2011	John Doe	2222222222	10/29/2011 10/29/2011	OS	SURGICAL CNTR LLC	GA	111-22-3333	99807205

Confidential and

12. After clicking on the DCN on the index page, you will arrive at the update page (*example on next page*).

The following fields are 'open' to be completed by the IPA:

- **Internal Reference Number:** The IPA has the option to enter a number to identify the member, i.e., medical records #, patient account #, etc. Field is freeform, alpha/numeric, up to 13 characters.

- **GA - Group Approved / / to / /**
 - Check the box by right clicking on your mouse.
 - This box should be checked, and no date ranges entered if the entire stay has been managed by one of the IPA's physicians or referred by an IPA physician.
 - Dates are entered if the claim is partially group-approved. Enter the dates that the claim should be paid as group approved.

- **NGA - Not Group Approved / / to / /**
 - Check the box by right clicking on your mouse.
 - This box should be checked, and no date ranges entered if the entire stay has **not** been managed by one of the IPA's physicians or referred by an IPA physician.
 - Dates are entered if the claim is partially group approved. Enter the dates that the claim was **not** managed by one of the IPA's physicians or referred by an IPA physician.

- **MGR - Med Group Risk**
 - Check the box if you have determined that you would prefer to change the financial risk and the claim will be paid by the IPA in full.
 - The claim must be paid timely by the IPA.
 - No units will be charged on the UM Fund.
 - The claim will not be processed under reinsurance.

- **Comments:**
 - 200 characters, alpha/numeric
 - To be used when you want to send additional information

- **Approver:**
 - 3 characters, alpha/numeric
 - For IPA internal use to document who submitted group approval status

- **User:**
 - Will be pre-filled with the name of the person who has signed on.

February 10, 2012




Home > 095-Request for Group Approval Status Report > 095-Request for Group Approval Claim Update

HMO Eligibility

Eligibility List
Changes Since Last Eligibility List
Members Address List

HMO Financial

Capitation
Reconciliation Report
Capitation Summary Report
Activity Counts
Capitation by Benefit Plan
Age and Gender Counts

HMO Claims

095 - Request for Group Approval Status List
Past Due Claims(PDC) - 10 Day Notice List
039 - Medical Group Risk Claims List

Resources

Provider Manual
Benefit Matrix
Benefit Matrix Numeric
Benefit Matrix Alpha

095-Request for Group Approval Claim Update

Report Date: 02/07/2012 **Patient Name:** Jane Doe
Group Number: H1234 **Subscriber ID:** 111111111111
Date of Birth: 02/12/1964 **Prov Name:** ABC Medical Practice
Claim Days: 27 **Provider Telephone:** (312) 123-4567
From Date: 01/03/2012 **DCN Number:** 222222222222
To Date: 01/30/2012 **Total Charge:** \$390,161.00
Bill Type Code: 111 **ER Admit:** N
Procedure Ind: IP **Subscriber SSN:** 111-11-1111

Diagnosis Codes		
0389 M	042	51881M

Procedure codes		
3322	3328	3421
3893	9604	9671
9672		

Approval Status Entry

Internal Reference Number:

GA - Group Approved / / to / /

NGA - Not Group Approved / / to / /

MGR - Med Group Risk

Comments:

Approver:

User:

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13. To return to the listing of claims click on the breadcrumb, 095-Request for Group Approval Status Report:

[Home](#) > [095-Request for Group Approval Status Report](#) > [095-Request for Group Approval Claim Update](#)

14. From the list window, if you click on a DCN for a claim that has already been updated by a member of your staff, you will arrive at a 'read-only' claim window.

February 10, 2012




Home > 095-Request for Group Approval Status Report > 095-Request for Group Approval Claim Update

HMO Eligibility	095-Request for Group Approval Claim Update								
<ul style="list-style-type: none"> Eligibility List Changes Since Last Eligibility List Members Address List 	<p>Report Date: 11/08/2011 Patient Name: John Doe</p> <p>Group Number: H11111 Subscriber ID: 222222222222</p> <p>Date of Birth: 03/03/1945 Prov Name: XYZ Hospital</p> <p>Claim Days: 0 Provider Telephone: (312) 222-3333</p> <p>From Date: 10/11/2011 DCN Number: 999999999999X</p> <p>To Date: 10/13/2011 Total Charge: \$1,556.00</p> <p>Bill Type Code: 721 ER Admit: N</p> <p>Procedure Ind: Subscriber SSN: 333-33-3333</p> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th colspan="2">Diagnosis Codes</th> </tr> </thead> <tbody> <tr> <td style="width: 50%;">5856</td> <td style="width: 50%;"></td> </tr> </tbody> </table> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th colspan="2">Procedure codes</th> </tr> </thead> <tbody> <tr> <td style="width: 50%;"></td> <td style="width: 50%;"></td> </tr> </tbody> </table>	Diagnosis Codes		5856		Procedure codes			
Diagnosis Codes									
5856									
Procedure codes									
<ul style="list-style-type: none"> HMO Financial Capitation Reconciliation Report Capitation Summary Report Activity Counts Capitation by Benefit Plan Age and Gender Counts 	<p>Approval Status Information</p> <p>Status: Group Approved</p> <p>From Date: 10/11/2011</p> <p>To Date: 10/13/2011</p> <p>Last Changed Date: 11/11/2011</p> <p>Userid:</p> <p>Internal Reference Number:</p> <p>Approver:</p> <p>Comments:</p>								
<ul style="list-style-type: none"> HMO Claims 095 - Request for Group Approval Status List Past Due Claims(PDC) - 10 Day Notice List 039 - Medical Group Risk Claims List 									
<ul style="list-style-type: none"> Resources Provider Manual Benefit Matrix Benefit Matrix Numeric Benefit Matrix Alpha 									

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Trouble Shooting Tips

What if I make a mistake?

If you submit a claim on the website with an incorrect response, follow the instructions below:

1. Open the claim in question on the website
2. Make a screen print from the detail page that shows the status
3. On the screen print, write the corrected status
4. Make sure to explain the reason for the change in status
5. Sign and date
6. Print your name and the name of your IPA
7. For HMO Illinois, Blue Advantage HMO, Group Blue Precision HMO (Group number starting with “R”) and BlueCare Direct (Groups number starting with an “A”) products: email the claim to hmo inquiryrequests@bcbsil.com. For the Individual Retail Blue Precision HMO: email the claim to retailbphmoilcauhcmassistance@hscil.com. Send only one claim per email.

Note: If you are changing the status from group-approved to not group-approved, you must send your request to change the status within five calendar days of the original submission. This applies to all group approved claims and is not dependent upon method of response (e.g., verbal, paper, electronic). Please refer to HMO Financial Risk Claims Policy and Procedure 67, 67A.

Disclaimer: The intent is that you are correcting a mistake that you made when submitting the 095 response to BCBSIL. This is not intended for the use of submitting a response after the claim has been processed as Default Group Approval (DGA) because the IPA did not respond to the 095 report timely.

What if I can't access the Blue Access for Providers website?

Each IPA has identified an internal security officer. Discuss your issue first with your internal security officer. If you continue to have an issue, call the BCBSIL Help Desk at 312-653-6675 for Blue Access for Providers assistance.

What If I forgot my password or my sign on?

Call the BCBSIL Help Desk at 312-653-6675 for Blue Access for Providers assistance.

What if BCBSIL is having technical problems and the website is not available for us to work our claims?

If there are system issues and the website is unavailable for more than 24 hours, the HMO will make accommodations as needed.

Note: It is not advised to wait until day 10 to respond to the 095 claims.

What if I need a copy of the claim?

The IPA should attempt to contact the provider for a copy of the claim, especially if the services were rendered by a contracted provider. In the event you are unable to obtain a copy, you may contact our claims office at hmo claimrequests@bcbsil.com for HMO Illinois, Blue Advantage HMO, Group Blue Precision HMO (Group number starting with “R”) and BlueCare Direct (Groups number starting with an “A”) products. Send the request to retailbphmoilcauhcmassistance@hscil.com for the Individual Retail Blue Precision HMO (Group number starting with an “I”) products. **Please indicate the IPA name and number in the subject line of the email.** For PHI purposes, the body of the email will only need the DCN number of the claim. The claim will be faxed to the Past Due Claims (PDC) contact person identified by the IPA.

Where do I report other problems or if I have questions?

Please contact your Provider Network Consultant.

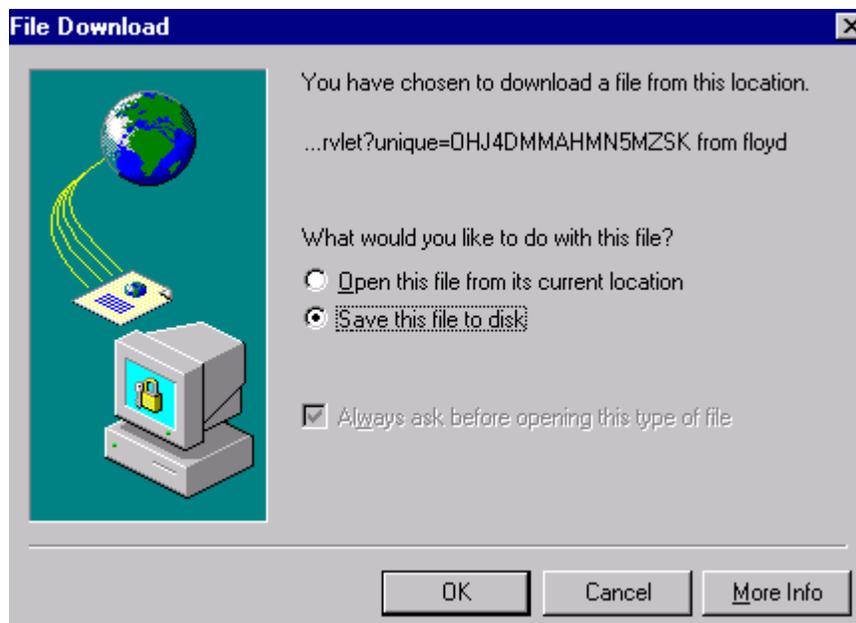
To Download Report

1. You can download (the full list) by clicking on the 'Download Data' button.

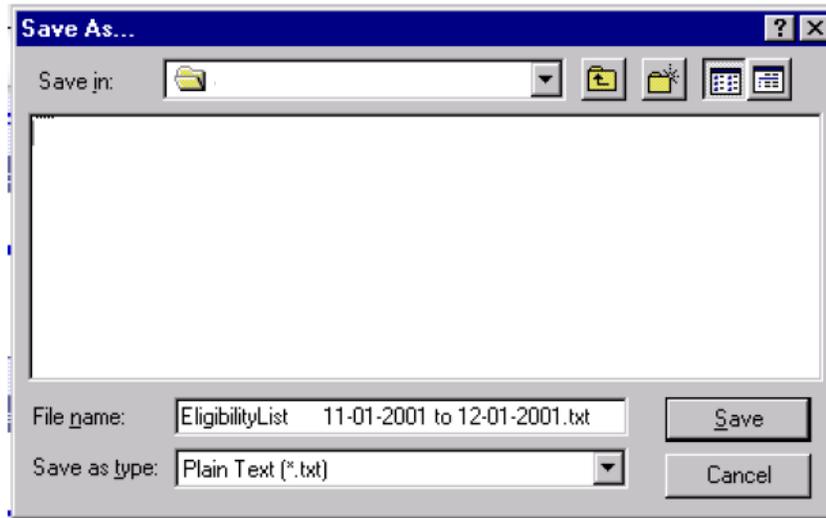
Download Data

2. Depending on your browser, you will receive a message box.

Internet Explorer: You will probably receive a File Download Dialog Box



3. Depending on your browser,
Internet Explorer: Click on the 'Save this File to Disk' radio button and click on 'OK'.
4. The 'Save As' window will appear.



Note: The file name defaults to the Report Name, IPA Number and Eligibility Period. However, you can change this if you want.

5. Verify the location where the file will be saved by reviewing the 'Save in' field at the top of the window. You can change this location as desired.
6. Click on the 'Save' button.
7. The file will be saved in a .txt format to the location selected (*step 19*).

Additional Functionality

Data Definition Table

1. To view a table with the data definitions of the report, click on the 'Data Definition' button.

Data Definition

2. The Data Definition table will be displayed in a pop-up window.



Field Name	Data Type	Length	Description
PROV_ID	Number	3	Contracting Entity Number
PROV_SEQ_NBR	Number	3	Medical Group Number
GRP_NBR	Character	6	Group Number
SUB_LAST_NM	Character	20	Subscriber("Family")Last Name
SUB_ID_NBR	Character	12	Subscriber Number (SSN)
LAST_NM	Character	20	Member Last Name -Could differ from subscriber Last Name
FIRST_NM	Character	20	Member First Name
BEN_PLAN_ABBR_CD	Character	6	HMO/BA Benefit Plan

3. You can close the data definition pop up window in one of two ways:

- a) Click on the 'Close' button at the bottom of the window.

Close

- b) Click on the 'x' button at the top of the window.



Clearing Search Form

1. To clear your search criteria at any time, click on the 'Clear' button.

Clear

2. The search form will be displayed. However, the results report that was displayed will not change.

Importing Downloaded File – Microsoft Access

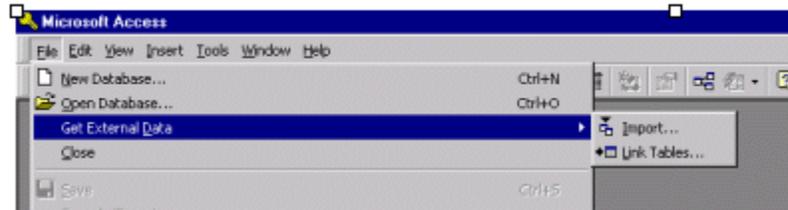
The following includes the steps to import a downloaded file into Microsoft Access. At many steps, pages in parentheses will refer you to the specific section in this document that discusses the page's elements in full detail.

Assumptions

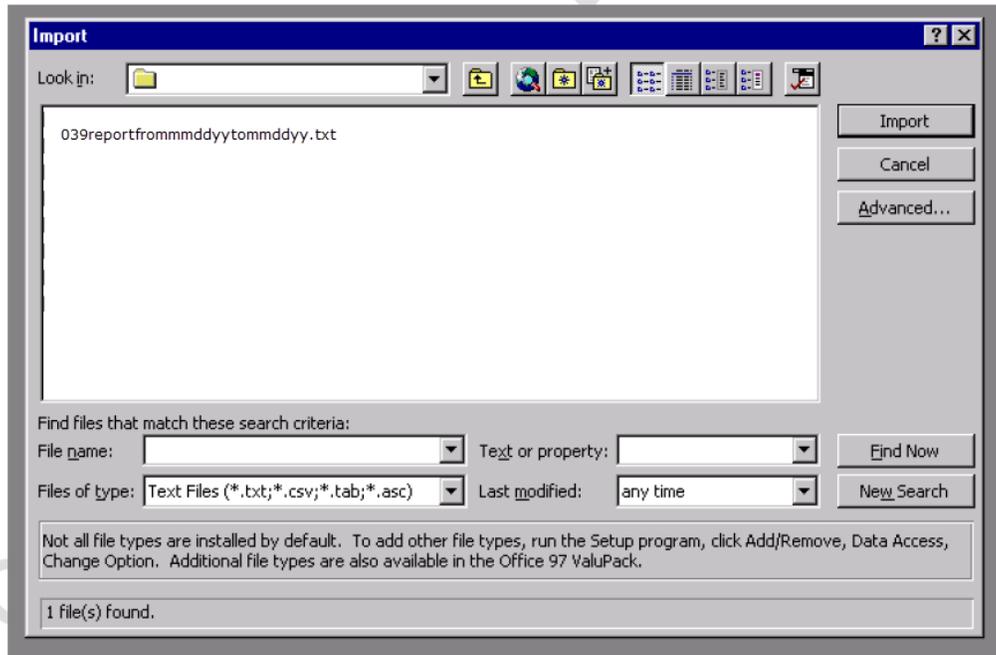
- User has a database open in Microsoft Access.

Instructions

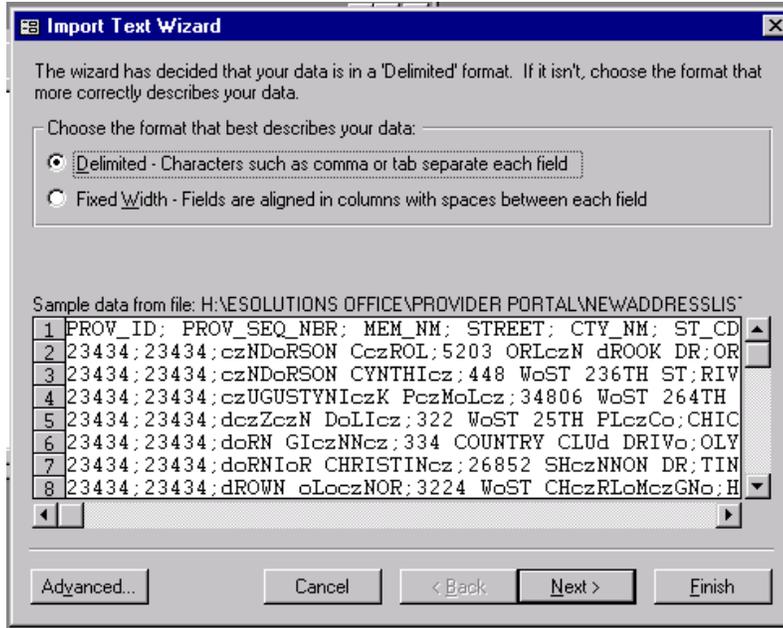
1. Open the database, in which you wish to import the data.
2. From the top menu, select 'File – Get External Data – Import.'



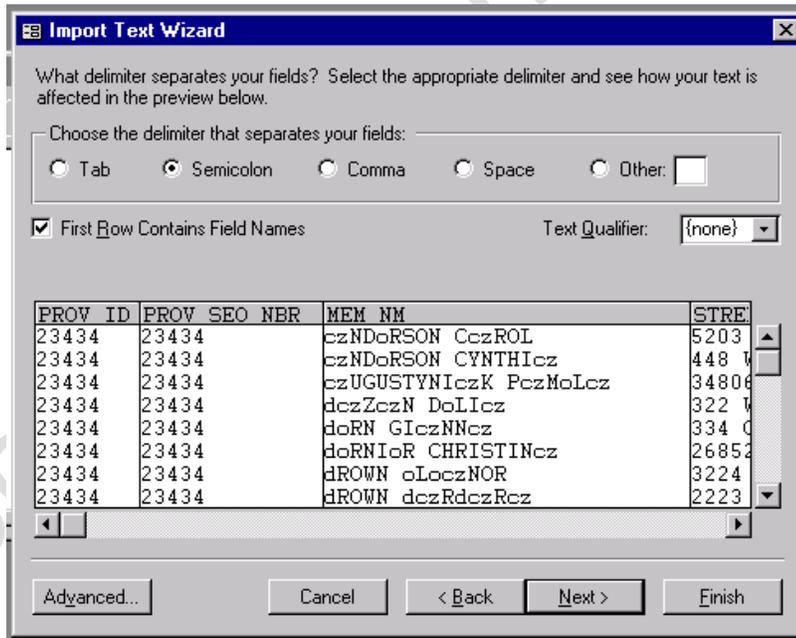
3. Find and select the downloaded file you wish to import (confirm you are looking in the right directory and that you have file type selected as text files).



- Click the 'Import' button.
- Select the 'Delimited' file type radio button.



- Click the 'Next' button.
- Select the Semicolon radio button for the delimiter.



8. Check the First Row Contains Field Names check box.
9. Click the 'Next' button.
10. Select where you want to import the data. You can:
 - a) import to a new table; or
 - b) select an existing table
11. Click the 'Next' button.
12. Optional step – if desired or necessary, you may specify information about your fields (by selecting the options presented).
13. Click the 'Next' button.
14. Select your primary key or allow Access to do it for you by selecting the appropriate radio button.
15. Click the 'Next' button.
16. Confirm the table name is where you want to import the file.
17. Click the 'Finish' button.
18. You will receive an information success box that your data was imported successfully.

Importing Downloaded File – Microsoft Excel

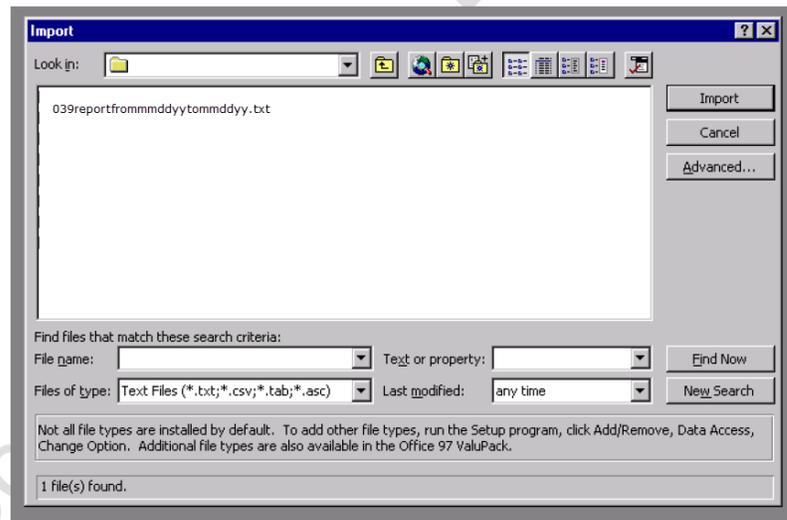
The following includes the steps to import a downloaded file into Microsoft Excel. At many steps, pages in parentheses will refer you to the specific section in this document that discusses the page's elements in full detail.

Assumptions

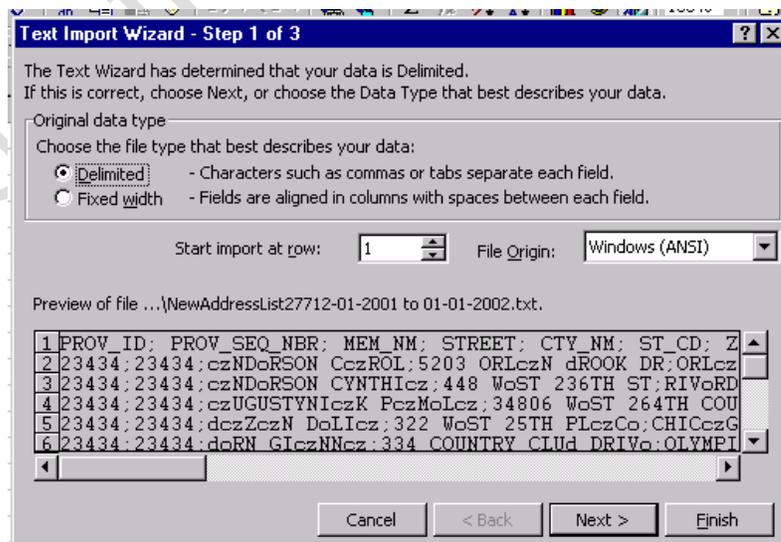
- User has a database open in Microsoft Excel.

Instructions

1. Open the file, in which you wish to import the data.
2. From the top menu, select 'Open'.
3. Find the downloaded file you wish to import (confirm you are looking in the right directory and that you have file type selected at text files).

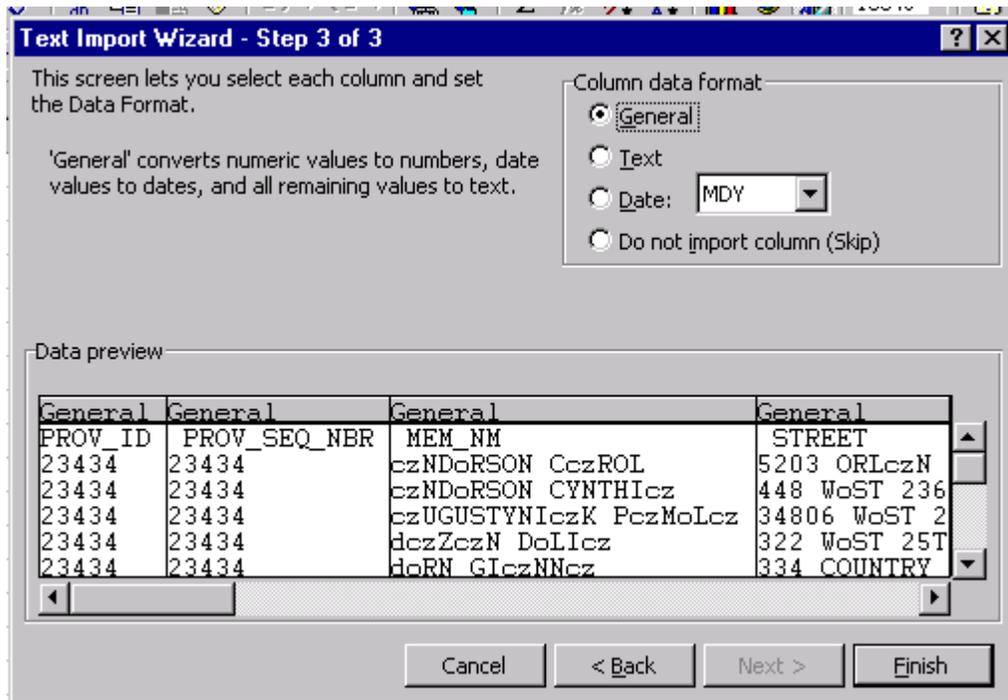


4. Click the 'Open' button. Select the 'Delimited' file type radio button.



5. Click the 'Next' button
6. Select the semicolon check box for the delimiter.
7. Click the 'Next' button.
8. Select the column data format that you wish to use (general, text, date or do not import) for each column.

Note: For the Eligibility List file and the Capitation by Benefit plan, you must select text data format for the BEN_PLAN_ABR_CD field.



9. Click the 'Finish' button.
10. Your data will be imported to your open Excel spreadsheet.

IPA Responsibility Claims

Payment should be made on valid referral bills within 30 days of receipt by the IPA, per the Medical Service Agreement.

If claim is Non-Group Approved (NGA) it should be stamped NGA and forwarded to the HMO.

The IPA should have written service agreements for all providers that are used regularly. These service agreements must include that provider agrees to all terms set forth in the MSA and Provider Manual, including, but not limited to:

- provider responsibilities
- agreed upon compensation, at least in general terms
- requirement that provider submit a claim no less than 90 days after date of service if the HMO is the primary insurance
- agreement to seek compensation not from HMO or Member but solely from the IPA for services provided to Members
- agreement to participate in quality of care review activities as requested by the IPA, including allowing access to medical records for HEDIS reporting and other HMO quality improvement initiatives
- professional liability insurance coverage as specified in the MSA
- agreement to preserve patient confidentiality
- agreement not to charge any Participating IPA more than the Blue Cross Blue Shield of Illinois PPO Schedule of Maximum Allowance for referred or Emergency covered services provided to Members of such Participating IPA if such claims are paid within 30 days of the Participating IPA's receipt of such claims unless payment was delayed as a result of the Member's eligibility for an Advance Premium Tax Credit Grace Period. IPA Physicians agree to accept the Blue Cross Blue Shield of Illinois PPO Schedule of Maximum Allowance for referred or emergency services provided to Members of such Participating IPA if such claims which are determined to be eligible for payment are paid within 30 days following the required 3-month grace period.
- an agreement to comply with the terms of the MSA and Provider Manual

The HMO reserves the right, as outlined in the MSA, to pay a claim on behalf of the IPA. The HMO will deduct billed charges from the IPA's monthly capitation.

Immunizations Claims: HMO Risk

- COVID-19, Influenza, RSV (Adult/Pediatric) and Shingles only, are covered under the members pharmacy benefit (Prime Therapeutics) if applicable and medical benefit.
- HMO will reimburse IPA providers for the immunization and administration fees when the above vaccinations are administered in IPA office or outpatient setting.
- Claims for vaccinations DO NOT require "stamped" approval status.
To avoid claim processing delays, IPA providers are encouraged to submit claims directly to the HMO for the vaccination/administration fees ONLY.

Out-of-Area Claims

Out-of-area is defined as being more than a 30-mile radius of the IPA Physician or IPA Affiliated Hospital site in which the Member is enrolled. If an IPA refers and approves services for a member that is more than 30 miles away, the standard financial responsibility applies.

If an IPA did not approve or refer the member for an out-of-area service, the IPA should stamp the claim Non-Group Approved (NGA)/OUT OF AREA and send it to the HMO.

The HMO pays all charges for outpatient, physician, ancillary and hospital services for a resulting admission, provided services meet the Out-of-Area Emergency Criteria. Medically Necessary follow-up care that must occur before members return in-area is also in benefit.

No units are charged against the Utilization Management Fund for NGA Out of Area hospital admissions. Whenever possible, the IPA should attempt to bring the member back into the service area when the patient is stable, and it is medically appropriate.

Dependents who are away at an out-of-area school may seek services at an emergency center or hospital emergency room for conditions that are emergencies and for those that need immediate care (e.g., sprains, lacerations, severe infections, etc.). All such services will be payable by the HMO. Such conditions as colds, sore throats, stomach flu, or basic physical examinations can be taken care of at the local student health center or private physician's office and are not covered by the HMO. Non-urgent diagnostic testing and elective surgical procedures are also considered not in benefit out-of-area. (*Refer to Away from Home Care/Guest Membership in this section for more information regarding out-of-area students.*)

Away from Home Care/Guest Membership

BCBSIL offers Away from Home Care (AFHC) to HMO members. Services covered through the AFHC program include emergency/accident care; follow up care and ongoing treatment when a member is out of the HMO service area. Services that are started at home and need to continue out of area (such as physical therapy for an out of state college student) may also be in benefit through the AFHC program. The member should be directed to call the customer service number on the back of their ID card for assistance.

Guest Membership services may also be in benefit for HMO Illinois and Blue Advantage HMO members. Blue Precision HMO, and BlueCare Direct members do not have the Guest Membership benefits.

Guest Membership is a courtesy membership for HMO members who are temporarily residing outside of their Home HMO service area. Members receive temporary enrollment in a participating host HMO and access to a wide range of benefits, including routine and preventive services.

The member must be planning to reside outside of their home HMO service area for at least 90 days to qualify. The member can then become a guest member of the BCBS HMO plan serving the area where they will be staying. This coverage applies to members who are:

- Long-term travelers
- Families living apart from the subscriber
- Students away at school
- Employees on extended work assignments

Membership

Most Guest Memberships are valid for a maximum of 1 year and can be renewed. The group numbers used for hosted guest members of BCBSIL HMO are: **G64555 and G64556**. If you are a PCP that participates in our HMO product, you may provide services to a guest member from another BCBS HMO plan who selected you as their Primary Care Physician. Please note that guest members from another BCBS HMO plan do not appear on any HMO eligibility listing.

Benefits

Guest members are entitled to coverage with BCBSIL HMO plan benefits. Hospital, physician, emergency room, X-ray and lab charges are covered by using their Guest Member ID card from our plan. Referrals to a specialist are still required but can be written on your regular order pad. Guest members should be directed within the HMO network for all their care. Prescriptions are covered by using their Home HMO Member ID card.

Note: BCBSIL should be contacted if the member needs Behavioral Health benefits, as some Home plans use their own network, even out-of-area.

Claims

Claims for services rendered to guest members should be submitted directly to BCBSIL HMO. They can be submitted electronically using the guest member information appearing on their Illinois ID card. Payment is made on a PPO fee schedule.

Questions

HMO providers should contact their IPA or call the customer service number on the back of the Member's ID card if more information is needed about guest membership.

Out-of-Plan Claims

Out-of-Plan is defined as being within 30 miles of the service area of the IPA but not group-approved.

The IPA is expected to become involved immediately upon notification of any Emergency Out-of-Plan admission. The IPA will be responsible to authorize care according to medical necessity. If the member is not stable, they will remain at the Out-of-Plan facility until medically appropriate to transfer or be discharged. The IPA is financially responsible for all emergency room professional charges as well as the professional charges from the point of notification through discharge. The Facility claim should be stamped Non-Group Approved for the period prior to the IPA being notified; and Group-Approved for the period after the group was notified. Units are charged to the Utilization Management Fund according to the Medical Service Agreement.

If the member is stable (as determined by the Primary Care and Attending physicians), they can be transferred to an In-Plan facility or discharged. The units are charged against the Utilization Management Fund accordingly.

If the IPA is not notified during the admission, the claim should be stamped Non-Group Approved and sent to the HMO.

Emergency Room or Emergency Admission Claims

The IPA is financially responsible to pay professional charges for all in-area emergency room services, subject to the HMO's determination that the services meet the definition of an emergency medical condition.

An admission may occur as a result of an emergency room visit. The IPA is expected to become involved immediately upon notification of any in-area emergency admission. In addition to the emergency room professional charges, the IPA is responsible for all professional charges from the point of notification through discharge. The units will be charged to the Utilization Management Fund according to the Medical Service Agreement.

Note: More information can be found in the Utilization Management and Population Health Management Plan Section of this manual regarding how to perform Utilization Management for these types of admissions.

Infertility Claims

Infertility claims and claim inquiries for services provided by HMO contracted providers should be forwarded to:

Winfertility, Inc.
1 American Lane – Terrace Level
Greenwich CT 06831
877-444-7271

If the IPA personnel refer a member to a non-contracting Infertility provider, the professional charges become the IPA's financial responsibility. When applicable, all units will be charged against the IPA's Utilization Management (UM) Fund if a non-contracting provider is used. Normally, no units are charged against the fund.

Covered Services Expense Limitations – Out of Pocket Maximum (OPX)

A member may have a Covered Services Expense Limitation, otherwise known as an "out-of-pocket maximum." This amount may vary per Employer Group. Refer to the HMO Benefit Matrix for additional information.

The HMO will track the member's accumulated liability (that includes copayments, deductibles and co-insurance, as applicable). When the member has reached their OPX, no further copayments should be collected. The HMO provides a report (Members OPX Met List) of members that have met their OPX limit. This report can be accessed at https://providers.hcsc.net/providers/il_login.html. This OPX report is updated daily (Mon – Fri). Once a member has met the OPX limit, the member's benefit plan will be changed to reflect a zero-copayment plan. If the member was added to the OPX report with a retroactive effective date, the IPA should review all claims paid for that member to verify if any copayments need to be refunded to the member.

During the initial set-up the HMO will send the identified IPA staff an OPX test password and test cases. Upon receipt of the test password, the IPAs can immediately submit an OPX test file. This email will include a naming nomenclature for the OPX file. The OPX file name should be in ALL CAPS as follows:

HMO_OPX_TRADINGPARTNERID_MMDDYY_SEQNBR.TXT
(Trading Partner ID will be sent with the password, SEQNBR =1, 2, 3 etc)

The IPA will need to submit a weekly file to the HMO that includes information on all for which a copayment was collected or refunded. The file must be in the HMO required format, and will be submitted using an SFTP server. Below is a list of software vendors that some of our trading partners utilize to submit data transactions to the HMO.

- Axway Synchrony Gateway Interchange
- Liaison Technologies
- GXS
- Sterling Gentran
- FileZilla
- WinSCP
- IPSwitch

The following rules apply for the submission of the OPX files:

1. Use the correct file name that was included in the initial set-up e-mail regarding the OPX password. The file name should be in ALL CAPS: HMO_OPX_TRADINGPARTNERID_MMDDYY_SEQNBR.TXT (Trading Partner ID will be sent with the password, SEQNBR =1, 2, 3 etc).
2. Only one file per day per IPA should be submitted.
3. The file is limited to 36,000 records. If the file has more than this, split the file into two (2) submissions and file separately.

4. Each file should have a unique name. If the IPA is re-submitting a file due to an error or splitting a file in half due to the size, the file name should only be used once. The re-submitted file should be named differently than the original file.
5. The file should be submitted after 4:00 AM and before 10:00 PM Monday – Friday only. Do not submit a file on the weekend or the following holidays:
 - a. New Years Day
 - b. Martin Luther King Jr. Day
 - c. Memorial Day
 - d. Juneteenth
 - e. Independence Day
 - f. Labor Day
 - g. Thanksgiving Day
 - h. Day after Thanksgiving
 - i. Christmas Day
6. The IPA must send an email to HMOCAUUnit@bcbsil.com if a file is not going to be submitted due to no OPX claim data for the week. The subject line on the email needs to read: MG # - No OPX file sent week of month/date/year (i.e., 01/01/2018).
7. Sender ID @pSENDER_ID - Use the Sender ID that was included in the initial set-up e-mail regarding the OPX password.
8. Unique Record ID @p RECORD_INFO – The Record ID is created by the IPA. Populate this field with a unique identifier for each record. It is imperative that the Record ID is unique for each record. If a file is submitted with a duplicate Record ID the file will be rejected as a duplicate.
9. The OPX file is not a cumulative file - only submit the copay information one time.
10. Accumulator Amount @pMEAC_AMT1 – the copay should be populated with a decimal (example 24.00).
11. Do not submit zero copays.
12. If only the dependent is assigned to an IPA the subscriber last name can be found on HMO eligibility list.
13. Make sure all fields are populated with the appropriate information. If one record is incorrect the entire file will be rejected
14. When a file is submitted it will immediately disappear, do not resubmit the file multiple times
15. If a copayment is refunded to the member, the refund must be submitted as a negative copay in the OPX file submission.
16. If the IPA discovers an error in submission of a copay, a negative adjustment should be submitted to correct the error.

Additional Information regarding SFTP Communications and the OPX file layout can be found on the BCBSIL IPA Access Portal. The Web address for the portal is: <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>. The documents can be found under the Provider Network Management tab in the HMO Out of Pocket (OPX) Maximum Information folder. If you do not have access to the portal, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf

Process Used by the HMO to Recover Overpayments

If an HMO overpayment is identified by the IPA, the IPA must notify the HMO within 10 calendar days. The IPA must refund any amounts due to the HMO within 30 calendar days, unless otherwise instructed by the HMO in writing. The HMO reserves the right to deduct the amounts owed from current or future payments due to the IPA.

Reinsurance Claims

The HMO reinsures an increasing portion of the medical benefit costs incurred by the IPA, as defined in the Medical Service Agreement (MSA). Reinsurance claims are calculated based on the Encounter Data submitted by the IPA to the HMO.

Encounter Data must meet the submission requirements as defined in the MSA, this manual and in the Encounter Companion Guide located on the BCBSIL IPA Access Portal at <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>.

IPAs will receive a monthly report via the Cotiviti portal showing which members and their respective claims exceed the predetermined threshold tier amount and are therefore eligible for reimbursement. The IPAs will also receive reports via the same portal that indicates which claims will not be considered for reinsurance. The Cotiviti portal can be accessed at <https://medicalintelligence.cotiviti.com/>. If you do not have access to the portal, complete and submit the form located here:

https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

The HMO will reimburse the IPA a portion of the IPA incurred costs, according to the reinsurance process document located on the BCBSIL IPA Access Portal at <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>. This payment will be added to the monthly capitation payment. A member level detailed report of the reinsurance payment will be available on the BCBSIL IPA Access Portal.

Reinsurance Calculation

- Catastrophic claims will not be considered for reinsurance.
- IPA risk claims and Encounter Data that are newly paid/adjudicated will be processed for reinsurance. IPAs will be notified of apparent duplicate claims which will not be considered for reinsurance unless they are corrected in subsequent monthly submissions.
- Claims which are the HMO's financial responsibility to pay will not be considered for reinsurance, even if the IPA has paid the charges.
- Coordination of Benefits with a Primary Payer and/or Medicare must be concluded prior to submitting risk claims and encounter data, and the paid amounts should be net of COB; the HMO will not consider capitated services when the HMO is not primary.

Refer to the MSA and the reinsurance process documentation that can be found on the BCBSIL IPA Access Portal. The Web address for the portal is <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>. The documents can be found under the Provider Network Management tab in the HMO Reinsurance Information folder. If you do not have access to the portal, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

Threshold Calculation

To be eligible for reinsurance, the IPA must pay IPA-responsible charges incurred by any one member in any one Agreement Year up to the threshold indicated in the MSA; the threshold may change on an annual basis. The HMO will then pay the IPA for 80%, 90% or 100% of additional eligible charges net of reinsurance already paid that exceed the threshold incurred for that Member in that Agreement Year, according to the terms outlined in the MSA. The table below outlines an example based on a reinsurance threshold of \$17,000.00.

IPA Payment

(Limited to BCBSIL Professional
PPO Fee Schedule)

\$17,000.00 in claims

IPA Responsibility

\$17,000.00

HMO Responsibility

(None)

The IPA has now met the Tier 1 threshold of \$17,000.00 and is at the 80% reimbursement level.

\$130,000.00 more in claims

\$26,000.00 (20%)

\$104,000.00 (80%)

\$147,000.00 total

\$43,000.00 total

The IPA has now met the Tier 2 threshold of \$43,000.00 and is therefore now at the 90% reimbursement level.

\$430,000.00 more in claims

\$43,000.00 (10%)

\$387,000.00 (90%)

\$577,000.00 total

\$86,000.00 total

\$491,000.00 total

The IPA has now met the Tier 3 threshold of \$86,000.00 and is therefore now at the 100% reimbursement level.

Repriced
Amount

\$577,000.00

Threshold Level	IPA Out of Pocket Expense Per MSA Contract Terms		Threshold Level Groupings		Calculation by Threshold Level	Responsible Charges	
			From	To		IPA	BCBS
Threshold Tier 1	100%	\$17,000	\$0.00	\$17,000.00	\$17,000.00	\$17,000.00	\$0.00
Threshold Tier 2	20%	\$43,000	\$17,000.01	\$147,000.00	\$130,000.00	\$26,000.00	\$104,000.00
Threshold Tier 3	10%	\$86,000	\$147,000.01	\$577,000.00	\$430,000.00	\$43,000.00	\$387,000.00
Threshold Tier 4	0%	>\$86000	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

\$577,000.00 \$86,000.00 \$491,000.00

Questions/Problems

If there are questions or problems concerning reinsurance, please contact your Provider Network Consultant.

Non-Capitated Services (Catastrophic Claims)

There are several conditions that the HMO considers Non-Capitated (catastrophic). Group-approved services related to these conditions that are usually the IPA's responsibility become the HMO's responsibility. These situations are:

- **Voluntary sterilization**
 - Claims must be stamped **GA – Sterilization Related**
- **Extraction of completely bony impacted teeth**
 - Claims must be stamped **GA – Bony Impacted Related**
- **Organ transplants**, related pre/post-surgical laboratory and diagnostic tests performed by the designated transplant facility, and follow-up within 365 days of the transplant, provided IPA obtained prior approval for organ transplant from the HMO.
 - HMO Transplant approval letter must be on file.
 - Pre/Post-Surgical related claims must be stamped **GA -Transplant Related**
- **Transgender services** provided the IPA prospectively notified the HMO in writing as described in the Scope of Benefits section of this manual. All Transgender outpatient Behavioral Health services remain the IPA's financial liability.
 - HMO Transgender approval letter must be on file.
 - Transgender related claims must be stamped **GA – Transgender Related**
- **Drugs** (Specialty Pharmacy claims) administered to a homebound member by a home health agency, provided the IPA prospectively notified the HMO in writing as described in the Scope of Benefits section of this manual.
 - IPA Approval Letter (template) must be on file.
 - Specialty Pharmacy Claims must be stamped **GA – Homebound Related**

The IPA has two options:

1. The HMO will reimburse the IPA at the lesser of the amount paid or at the BCBSIL PPO Schedule of Maximum Allowance. The claims must be stamped "Group-Approved" and submitted on the Catastrophic Claims Form to the HMO Claims Department. (*See the next page for the sample Catastrophic Claims Form*)
2. The IPA also has the option to have the HMO pay the provider directly at the lesser of billed charges or the BCBSIL PPO Schedule of Maximum Allowance. Each claim must be stamped "Group-Approved." In addition, a note indicating the type of claim (voluntary sterilization, extraction of completely bony impacted teeth, organ transplant-related, transgender service or drugs related to homebound patients) If the IPA responds to a related HMO claim via the 095 report for group approval status, a note must also be included in the Comments field to indicate the type of claim as mentioned above.

PLEASE NOTE: If the IPA responds with "NGA – HMO liability," the claim will be denied as Not Group Approved for no referral.

Catastrophic Claim Form

HMO Illinois[®], Blue Advantage HMOSM, Blue Precision HMOSM, BlueCare DirectSM

Medical Group/IPA Name: _____

Medical Group/IPA Number: _____

Patient Name: _____

Group/ID #: _____

Payee Name: _____

Payee Address: _____

Payee City/State/Zip code: _____

DATE OF SERVICE	PROVIDER	DIAGNOSIS	TYPE OF SERVICE	BILLED AMOUNT	PAID AMOUNT

Itemized bills are attached

Past Due Claims (PDC) Process

Please refer to the HMO Policy and Procedure Section located on the BCBSIL website for more details on the Past Due Claims (PDC) process.

The PDC Challenge Form, as described in the policy, can be found on the BCBSIL IPA Access Portal at <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>. If you do not have access to the portal, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

Compliance with HMO Data Collections Requirements

The IPA must comply with Encounter Data reporting by providing a file containing all data elements required by the HMO and in a format and timeframe acceptable to the HMO. Additional information can be found on BCBSIL IPA Access portal at <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx> If you do not have access to the portal, complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

The Encounter Data must be complete and accurate – as verified by the HMO. If the data is incomplete or fails the audit for coding accuracy, the IPA must correct and resubmit records to HMO within 10 days from notification of the rejection.

In addition, the IPA must submit a quarterly Universal Encounter Data Validations as outlined in the MSA. Please refer to the HMO Submission Grid Overview document for additional information. Which can be found on the BCBSIL IPA Access portal <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>

Affordable Care Act (ACA) Grace Period Process Blue Precision HMOSM, BlueCare DirectSM

This section is applicable to the following HMO Products: Blue Precision HMO, BlueCare Direct and Blue FocusCare.

The Affordable Care Act (ACA) includes a provision that allows health insurance marketplace members who receive the advance premium tax credit (APTC), a three-month grace period to pay their premium – provided they have already paid at least one month’s premium in full. It is important to note that not all members who purchase coverage on the health insurance marketplace will receive the APTC.

The provision requires all payers to process claims (for covered services rendered) in the first month of the grace period. For covered services rendered during months two and three, payers must pend the claims.

During the three-month grace period, members are eligible for covered services under their plan; however, payers are not obligated to pay claims for the second or third month of the grace period unless and until the member has paid all outstanding premiums.

The IPA provides and authorizes services and process claims as specified in the following:

APTC Three Month Grace Period Process		
First Month	Second and Third Months	Fourth Month
<ul style="list-style-type: none"> • IPA can retrieve the Grace Period Report • Capitation will be paid to the IPA, irrespective of unpaid premium balances. • The IPA follows standard procedures for all services and referrals. • Referrals that extend beyond the first month of the grace period must include notification to the referring provider that the member is in a grace period and services may become the member’s liability. • Group approved claims should be processed according to the member’s benefits. 	<ul style="list-style-type: none"> • Capitation will continue to be paid by the HMO. • All eligibility reports and verification systems established by the IPA need to inform providers that the member is in a grace period. *(The notification must include HMO required language.) • Referrals for services must include notification that the member is in a grace period and the payment for the cost of the services rendered may become the member’s responsibility. *(The notification must include HMO required language.) • IPA pends claims for authorized services rendered during the second and third months. <ul style="list-style-type: none"> • Providers must be notified of the claim status via an electronic or printed communication. • The communication must state the member is in a grace period and claims have been pended. • The notification must include the information found on the letter template: “Grace Period Months 2 and 3 Provider Notification Template – Claims Payment Status.” (See template at end of this section.) 	<p>Premium is Unpaid</p> <ul style="list-style-type: none"> • If the outstanding premium is not paid in full prior to the first day of the fourth month, the coverage will be cancelled retroactively to the last day of the first month of the grace period. The eligibility report will reflect the member no longer has coverage the first day of the second month. • Capitation will not be deducted for month one of the grace period • Capitation paid during the second and third months of the grace period will be retroactively deducted. • All pended claims should be processed and denied. • Provider may request payment for denied claims from the member for services rendered in months 2 and 3. <p>Premium is paid</p> <ul style="list-style-type: none"> • If member pays the premium balance in full prior to the fourth month, coverage will continue uninterrupted. • Within 10 days of notification that the member has paid their premium in full, the IPA should identify and process all pended claims.

*Please be aware this member is currently in a federally required grace period. The member must pay his or her overdue premium to bring the policy to a current status before any claims incurred during this period will be processed.

Grace Period for Non- APTC HMO Members

HMO members have a one-month grace period to pay their monthly premium. This applies to any HMO member who purchased their plan on or off the Marketplace and who do not receive the APTC.

The IPA provides and authorizes services and process claims as specified in the following:

Non-APTC HMO Members Grace Period	
First Month	Second Month
<ul style="list-style-type: none"> • Capitation will be paid to the IPA, irrespective of unpaid premium balances. • The IPA follows standard procedures for all services and referrals. • Group approved claims should be processed according to the member's benefits. 	<p>Premium is unpaid</p> <ul style="list-style-type: none"> • If premium balance is not paid in full by the end of month two, the policy is remains cancelled, retroactive to the first day of month two of the grace period. • Process and deny claims beginning with dates of service on the first day of month two and thereafter. • Provider may request payment for denied claims from the member. <p>Member pays Premium</p> <ul style="list-style-type: none"> • If member pays the premium balance by the end of month two, the member will be reinstated with no break in coverage. • Within 10 days of notification that the member has paid their premium in full, the IPA should identify all process all pended claims.

HMO Grace Period Report

The HMO will provide the IPA with a monthly Grace Period Report via the BCBSIL IPA Access Portal. The Web address for the portal is: <https://ipa.bcbsilezaccess.com/SitePages/Home.aspx>. The documents can be found under HMO Financial and Reporting CE Documents tab in the Grace Period folder. A template Data Definition/File Layout will be in the folder for reference.

If you do not have access to the portal, complete and submit the form located here:

https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf once a member has entered the first month of the grace period or transitioned to the second and third months of the grace period, the member will be added to the report.

Confidential and Proprietary

Grace Period Months 2 and 3 Provider Notification Template - Claims Payment Status

Date

PROVIDER NAME

PROVIDER ADDRESS

PROVIDER CITY STATE ZIP

Claim Information

Patient Name

Claim #

Group/ID # Service

Date Prov. Pat. No

Subject: Grace period notification about your patient

Dear <PROVIDER>:

Your claim for care provided under the [choose appropriate product for member - **Blue Precision HMOSM, BlueCare DirectSM XXX (enter metallic level)**] plan to <MEMBER> on <DATES OF SERVICE> is on hold pending the member's payment of the premium.

This member purchased the [choose appropriate product for member - **Blue Precision HMO, BlueCare Direct XXX (enter metallic level)**] health insurance and currently receives a subsidy to assist with premiums. This letter is to inform you that this member and any covered dependents are currently in the second or third month of their grace period.

What this means to you

- This claim occurred during the second or third month of the member's (and any covered dependents) grace period and is on hold pending the member's payment of the entire outstanding premium ("the Premium").
- Any additional claims during the second and third month of the grace period would also be on hold pending the member's payment of the Premium.
- If the Premium is paid by the end of the grace period, these claims will be processed.
- If the Premium is not paid by the end of the grace period, these claims will be denied and you may seek reimbursement directly from the member.

With the Affordable Care Act, if an individual purchases health insurance through the Marketplace and receives a subsidy to assist with premiums, there is a three month grace period when the individual can make premium payments. During this period, insurance companies consider these members active. However, we are required to notify providers that claims occurring in the second and third months will be denied if the premium is not paid during the grace period.

If you have specific questions about the grace period status for this member, the policy paid-to date is available via an eligibility and benefit quote either electronically (HIPPA 270/271) or by calling the HMO at 800-676-2583.

Sincerely,

Your Customer Advocate