BlueCross BlueShield of Illinois

Blue Cross Medicare Advantage HMO℠ Delegated Provider Manual 2025

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Related files:

Policy and Procedure page,
https://www.bcbsil.com/provider/standards/standardrequirements/manual/ma-hmo-policy-procedure
UM,
https://www.bcbsil.com/docs/provider/il/standards/manual/ma-hmo-policy-procedure/ma-hmoutilization-management.pdf

Nondiscrimination

HMO and the IPA may not deny, limit, or condition enrollment to individuals eligible to enroll in the Medicare Advantage plan offered based on any factor that is related to health status, including, but not limited to the following:

- Claims experience
- Receipt of health care
- Medical history
- Medical conditions arising out of acts of domestic violence
- Evidence of insurability including conditions arising out of acts of domestic violence and disability

Additionally, the HMO and its participating providers must:

- Comply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act, and the Genetic Information Nondiscrimination Act of 2008.
- Confirm that procedures are in place to ensure that members are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or source of payment.

Third-Party Premium Payments

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with Federal guidance, Blue Cross and Blue Shield of Illinois will accept third-party payment for premium directly from the following entities:

(1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations or urban Indian organizations; and (3) state and federal Government programs.

BCBSIL may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the Covered Persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSIL directly for any or all an enrollee's premium.

Confidentiality of Member Information

Participating Providers must comply with all state and federal laws concerning confidentiality of health and other information about members. Participating Providers must have policies and procedures in place regarding use and disclosure of health information that comply with applicable laws. HMO members have the right to privacy and confidentiality regarding their health care records and information. Participating physicians/professional providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member’s personnel file.

Basic Rule

HMO and its Participating IPAs must provide enrollees in the Blue Medicare Advantage HMO plan with all Part A and Part B Original Medicare services if the enrollee is entitled to benefits under both parts and Part B services if the enrollee is a grandfathered "Part B only" enrollee. The following requirements apply:

- Benefits: must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services.
- Access: enrollees must have access to all medically necessary Parts A and B services.
- Cost sharing: the HMO can impose cost sharing for an item or service that is above or below the Original Medicare cost sharing for that service, provided the overall cost sharing under the plan is actuarially equivalent to that under Original Medicare and the plan cost-sharing structure does not discriminate against sicker beneficiaries.

The following circumstances are exceptions to when the HMO and Participating IPAs must cover the costs of Original Medicare benefits:

- Hospice – Original Medicare will pay hospice for the services received by an enrollee who has elected hospice while enrolled in the plan. See Evidence of Coverage for details.
- Inpatient stay during which enrollment ends – Must continue to cover inpatient services of a non-plan enrollee if the individual was an enrollee at the time of admission of an inpatient stay.
- Clinical Trials – Original Medicare pays for the costs of routine services provided to an MA enrollee who joins a qualifying clinical trial. HMO and its Participating IPAs pay the enrollee the difference between Original Medicare cost sharing incurred for qualifying clinical trial items and services and the MA plan's in-network cost sharing for the same category of items and services.

Uniform

All plan benefits must be offered uniformly to all enrollees residing in the service area of the plan.

Benefits During Disasters and Catastrophic Events

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a governor or an announcement of a public health emergency by the Secretary of Health and Human Services, but absent an 1135 waiver by the Secretary, MA plans are expected to:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities
- Waive in full, requirements for gatekeeper referrals where applicable
- Temporarily reduce plan-approved out-of-network cost sharing to in-network cost-sharing amounts; and
- Waive the 30-day notification requirement to enrollees if all the changes (such as reduction of cost sharing and waiving authorization) benefit the enrollee.

Access and Availability

The following access and availability guidelines should be followed by Providers to ensure timely access to medical care and behavioral health care:

a) Routine and preventative care within 30 business days
b) Services that are not emergency or urgently needed, but require medical attention, within 7 business days.
c) Urgent, but non-emergent care within 24 hours of request
d) Urgently needed services or emergency – immediately

The guidelines above also apply to behavioral health services and substance use disorder services.

Participating Physicians/Professional Providers are expected to provide coverage for HMO members 24 hours a day, seven days a week. When a Participating Physician/Professional Provider is unable to provide services, the Participating Physician/Professional Provider must ensure that he or she has arranged for coverage from another Participating Physician/Provider. Hospital emergency rooms or urgent care centers are not substitutes for covering Participating Physician/Providers.

Adherence to member access guidelines will be monitored through the office site visits and the tracking of complaints/grievances related to access and availability, which are reviewed by the Clinical Quality Improvement Committee.

All contracted Physicians/Professional Providers and Hospitals must treat all HMO members with equal dignity and consideration as their non-HMO patients.

The HMO requires the IPAs to provide access to necessary specialist care and gives female members the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

After-hours access shall be provided to help ensure a response to after-hour phone calls. Individuals who believe they have an emergency medical condition should be directed to seek emergency services immediately.

For a more detailed overview, please refer to MA HMO Policies and Procedures.

Services Provided in Culturally Competent Manner

HMO is obligated to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds. Participating Providers must cooperate with the HMO in meeting this obligation.

The HMO Customer Service Department (phone number is listed on the back of the member's ID card) has available the following services for HMO Members:

- Teletypewriter (TTY) services
- Language services
  Spanish-speaking Customer Service Representatives

Preventive Services

Members may access certain preventive services from any Participating Provider in their medical group. The HMO covers, without cost sharing, all in-network Medicare covered preventive services for which there is no cost sharing under Original Medicare. Charges cannot be billed to the member for facility fees, professional services or physician office visits if the only service provided during the visit is a preventive service that is covered at zero cost sharing under Original Medicare. However, if during the provision of the preventive service, additional non-preventive services are furnished, then the HMO cost-sharing standards apply.

HMO members may directly access (through self-referral to any Participating Provider in their Medical Group) in-network screening mammography and administration of an influenza vaccine.

Out-of-Area Renal Dialysis Services

An HMO member may obtain medically necessary dialysis services from any qualified and appropriately licensed provider the member selects when he/she is temporarily absent from the HMO service area and cannot reasonably access the HMO dialysis provider. No prior authorization or notification is required. However, a member may voluntarily advise the HMO that he/she will temporarily be out of the service area. HMO may assist the member in locating a qualified dialysis provider.

Drugs Covered Under Original Medicare Part B

Subject to coverage requirements and regulatory and statutory limitations, the following broad category of drugs may be covered under Medicare Part B:

- Injectable drugs that have been determined by Medicare Administrative Contractors (MAC) to be "not usually self-administered" and are administered incidental to physician services
- Drugs that the HMO member takes through durable medical equipment (i.e., nebulizers)
- Certain vaccines including those for pneumococcal, hepatitis B (high or intermediate risk), influenza, COVID-19, and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition
- Certain oral anti-cancer drugs and anti-nausea drugs
- Hemophilia clotting factors
- Immunosuppressive drugs
- Some antigens
- Intravenous immune globulin administered in the home for the treatment of primary immune deficiency
- Injectable drugs used for the treatment of osteoporosis in limited situations
- Certain drugs, including erythropoietin, administered during treatment of End Stage Renal Disease (ESRD)

Some drugs are covered under either Part B or Part D depending on the circumstances. Please refer to the Evidence of Coverage for details.

Medical Supplies Associated with the Delivery of Insulin

Medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze and insulin injection delivery devices not otherwise covered under Medicare Part B, such as insulin pens, pen supplies and needle-free syringes, can satisfy the definition of a Part D drug. However, test strips, lancets and needle disposal systems are not considered medical supplies directly associated with the delivery of insulin for purposes of coverage under Part D. Please see Division of Financial Responsibility (DOFR) for detailed explanation.

Advance Directives

Participating Providers must document in a prominent part of the member's current medical record whether the member has executed an Advance Directive.

Advance Directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of the state of Illinois and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Medicare Low-Income Subsidy

This subsidy aids with premium, deductible, and co-payments of the program. Beneficiaries may apply for the Low-income Subsidy (LIS) with the Social Security Administration (SSA) or with their State Medicaid agency. Medicare beneficiaries who wish to enroll in the Medicare Prescription Drug Program must choose a prescription drug plan through which to receive the benefit. The member can start the process by calling 1-800 Medicare directly.

For more information, please see the links to CMS for LIS guidance:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources
https://www.cms.gov/Medicare/Eligibility-andEnrollment/LowIncSubMedicarePresCov/Downloads/StateLISGuidance021009.pdf

Membership Information

IPA Selection

The MA HMO requires that all members enrolled with the MA HMO products (MA HMO, MA HMO/POS, MA HMO Select) must select an IPA site.

Primary Care Physician Selection

The HMO requires* that all members enrolled with the HMO select a Primary Care Physician (PCP) who is affiliated with a contracted IPA site. Participating Providers may not designate themselves as a Primary Care Physician, for any purpose, for themselves or their Immediate Family Members. An "Immediate Family Member" is defined as: (i) current spouse; (ii) eligible domestic partner; (iii) parents and step-parents of the spouse or domestic partner; (iv) children and grandchildren (biological, adopted or other legally placed children) of the spouse or domestic partner; and, (v) siblings (including biological, adopted, step, half or other legally placed children) of the spouse or domestic partner. For purposes of this Section, “Participating Provider” means a licensed health care provider under the Illinois Medical Practice Act who is contracted with the IPA for the provision of covered services to members in accordance with the terms of the Medical Service Agreement.

Identification Cards

All eligible MA HMO/POS members are issued an Identification Card. Below are sample ID cards for the MA HMO Basic HMO, MA HMO Select, MA HMO/POS Basic Plus, MA HMO/POS Elite, and MA HMO Advantage Premier Plus HMO/POS products.

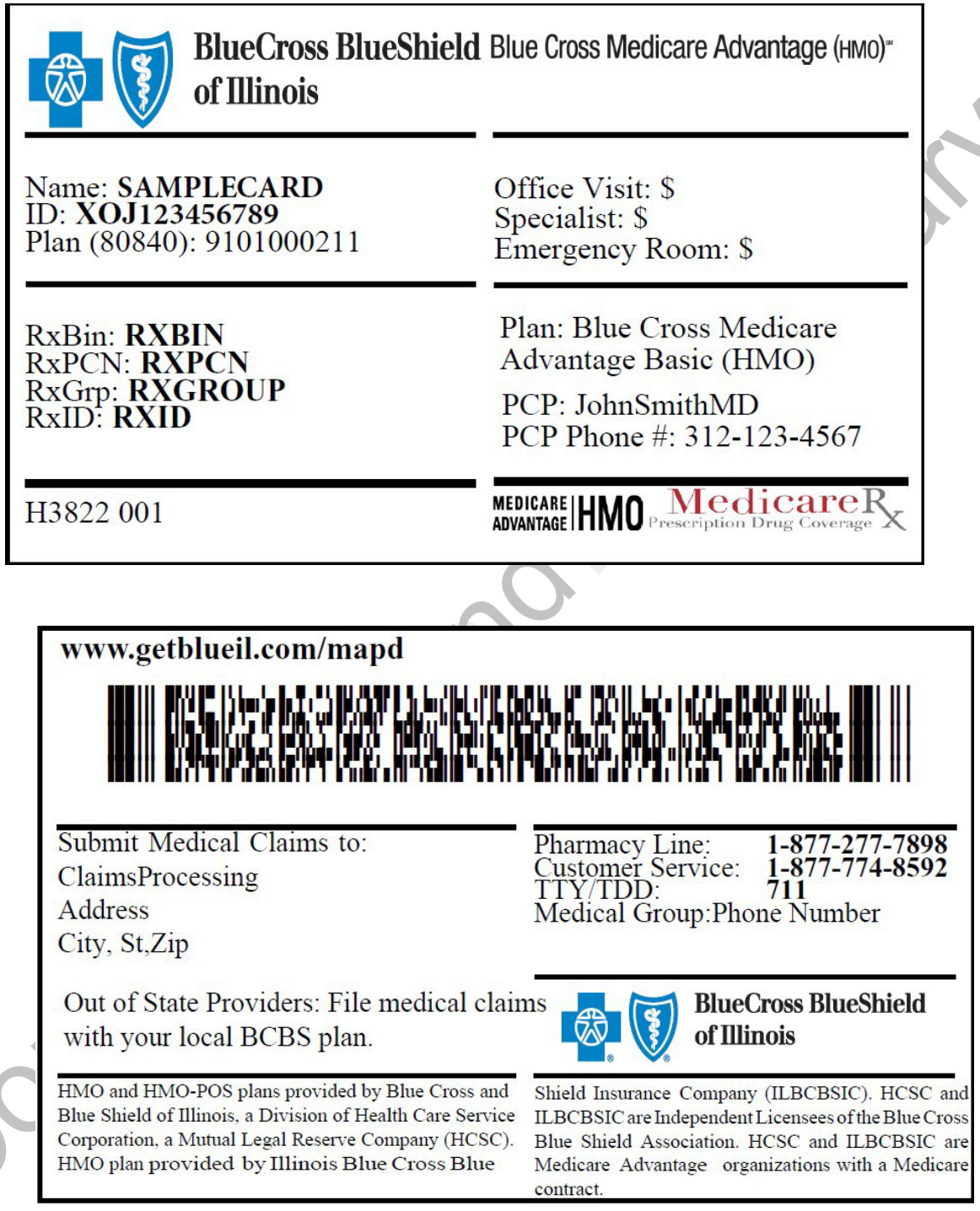
Identification cards are generated when:

- Member becomes eligible
- Member changes his/her name
- Member changes to a PCP who is affiliated with a different Medical Group
- Member changes IPA
- IPA Administrative Change, such as name or phone number

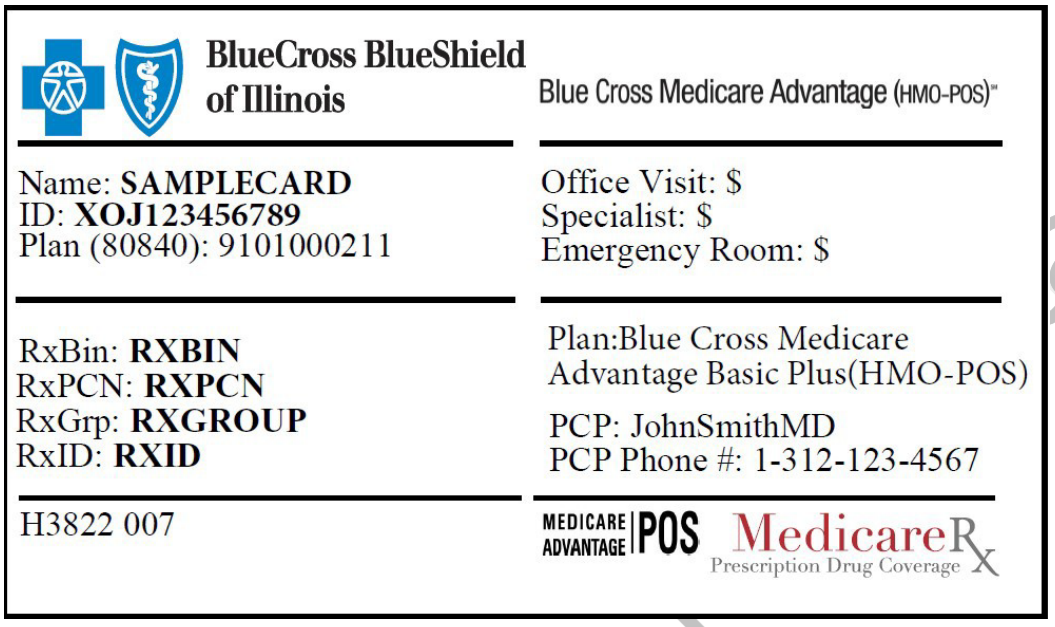
Each identification card contains the following information:

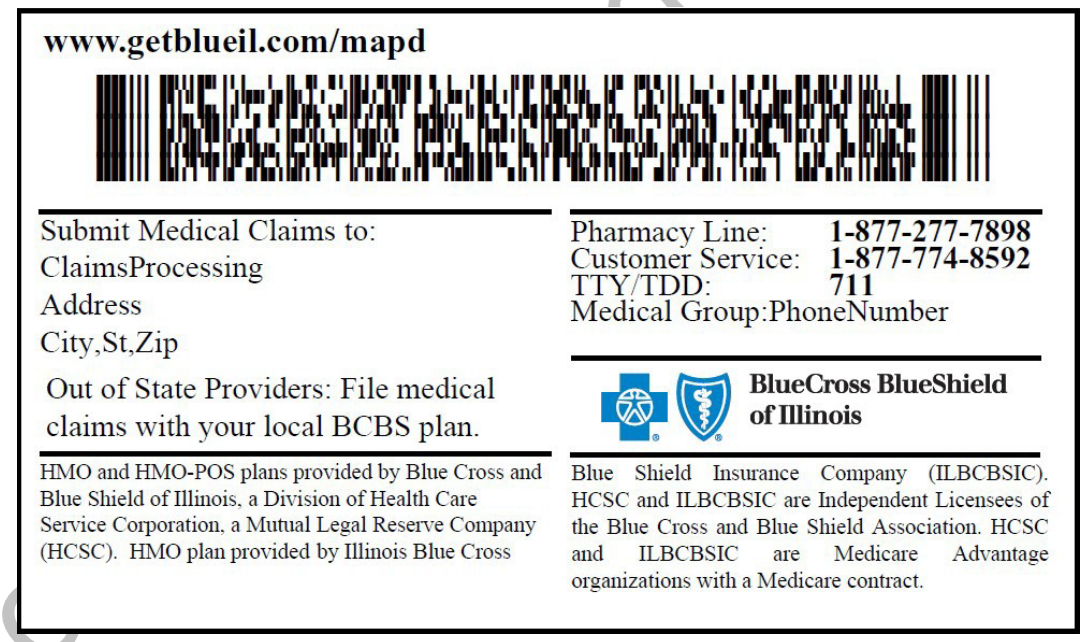
- Subscriber Name
- Effective Date - The member’s most current effective date (If a member has a status change or IPA change, the date will reflect the date of the change, not the original effective date with the MA HMO)
- IPA Name and Site Number - the unique number of the IPA that is assigned by the MA HMO/MA HMO-POS and selected by the member.
- IPA Phone Number
- PCP Name
- PCP phone number
- Prescription Drug Benefit Information
- Copayment Information

Medicare Advantage Basic HMO – H3822-001

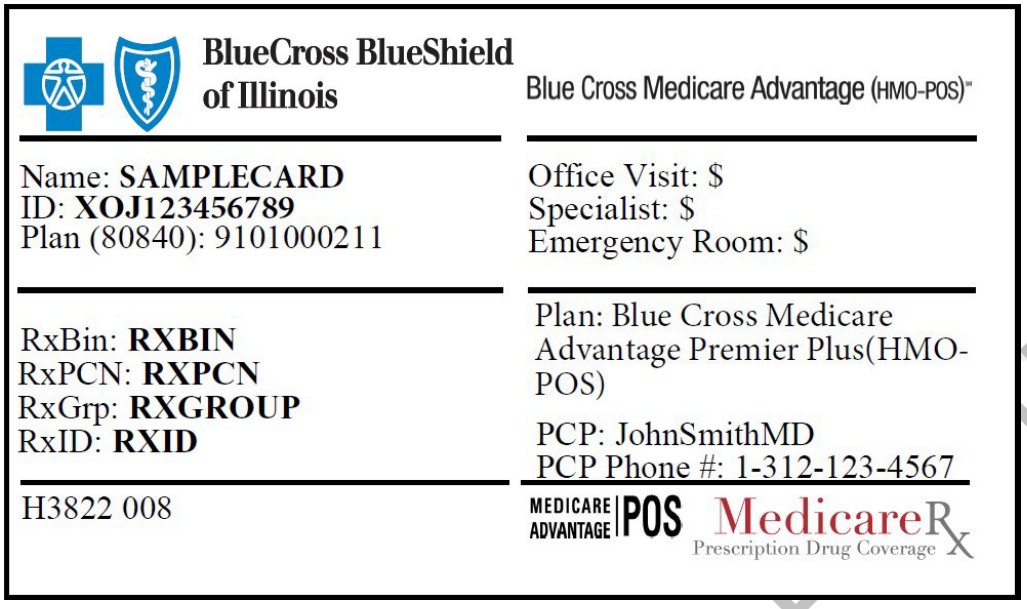


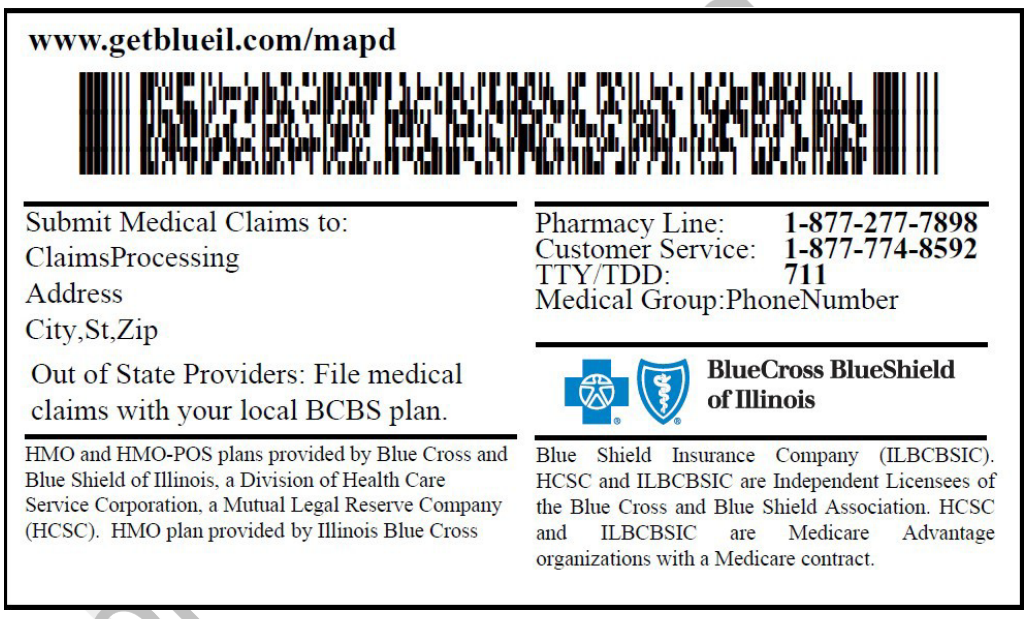
Medicare Advantage Basic Plus HMO/POS – H3822-007



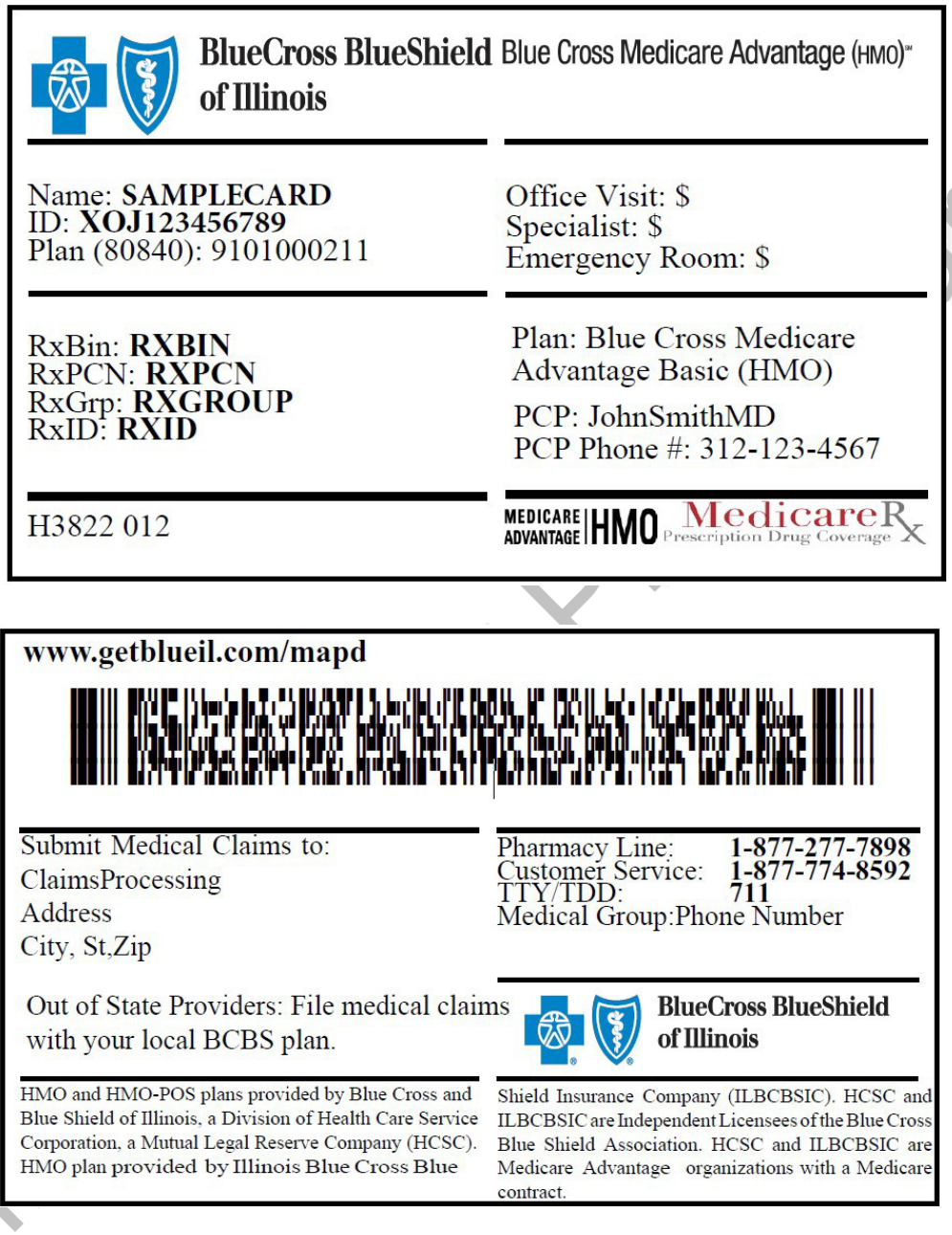


Medicare Advantage Premier Plus HMO/POS – H3822-008

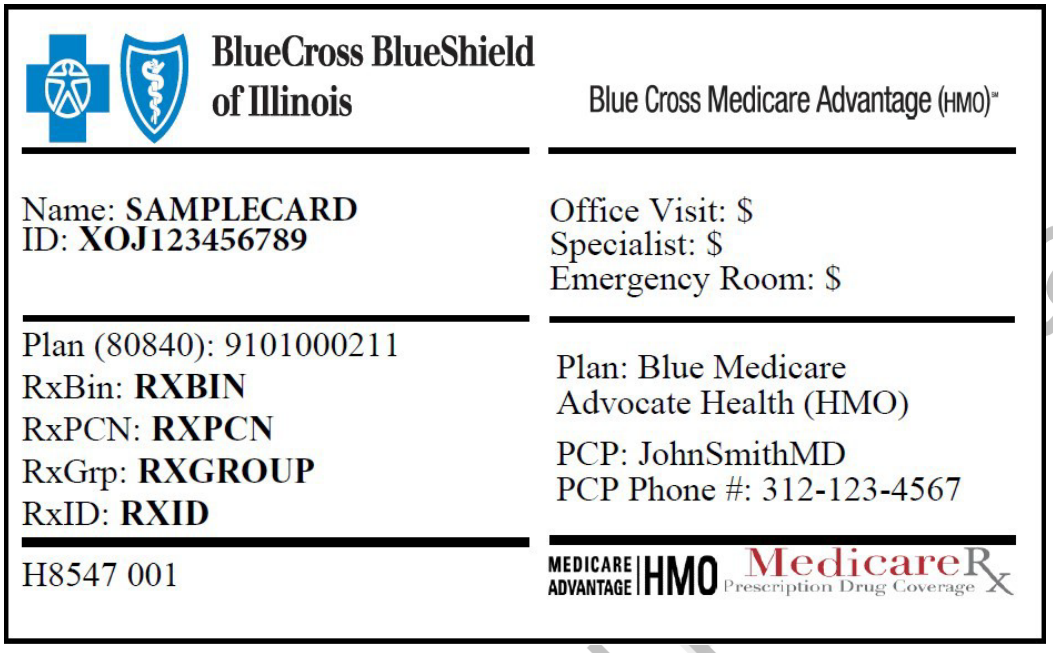




Blue Cross Medicare Advantage Basic (HMO) – (Central IL) H3822-012



Blue Medicare Advocate Health (HMO) – H8547-001


BlueCross BlueShield of Illinois

Blue Cross Medicare Advantage (HMO)℠

Name: **SAMPLECARD**
ID: **XOJ123456789**

Office Visit: $
Specialist: $
Emergency Room: $

Plan (80840): 9101000211
RxBin: **RXBIN**
RxPCN: **RXPCN**
RxGrp: **RXGROUP**
RxID: **RXID**

Plan: Blue Medicare Advocate Health (HMO)

PCP: JohnSmithMD
PCP Phone #: 312-123-4567

H8547 001

MEDICARE ADVANTAGE | HMO MedicareRx Prescription Drug Coverage

www.getblueil.com/mapd

Submit Medical Claims to:
ClaimsProcessing
Address
City, St,Zip

Out of State Providers: File medical claims with your local BCBS plan.

Customer Service: **1-877-774-8592**
TTY/TDD: **711**
Pharmacy Line: **1-877-277-7898**
Medical Group: Phone Number
Nurse Advice Line: **1-800-631-7023**

BlueCross BlueShield of Illinois

HMO plan provided by Blue Cross and Blue Shield of Illinois, which refers to Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC), an Independent Licensee of the Blue Cross and Blue Shield Association. ILBCBSIC is a Medicare Advantage organization with a Medicare contract.

Eligibility List

Prior to the first of each month, the MA HMO will provide the IPA with an alphabetical listing of all members enrolled with the group. The list details the members who are eligible to receive services at the IPA during the month and will be electronically posted to the HMO's secure web site Blue Access for Providers. Provider's who do not have access to the Blue Access for Providers website should contact their Provider Network Consultant.

A member may have an ID card and not appear on the Eligibility List. This will occur when the membership application is processed after the Eligibility List cut-off date. It is also possible that members may have ID cards after their eligibility has ended, since the MA HMO does not retract ID cards from cancelled members.

If a member has an ID card but does not appear on the Eligibility List, the IPA should call the HMO Customer Service Department at 877-774-8592, or providers can check Availity® Essentials or the Blue Access for Providers website. The IPA may also call the MA HMO number located on the back of the ID card. There is a Voice Response system for Eligibility Verification.

Note: The IPA is required to verify membership every visit prior to services being provided. The IPA should cross reference each Member's insurance card with his or her driver's license, passport or state identification card to ensure that the person presenting the card is the Member listed on the ID insurance card.

MA HMO Eligibility List and Capitation Report

This section illustrates and describes the MA HMO Eligibility List and Capitation Report online application. It covers how to navigate through the site using the many functions and options available. This document also details the steps for retrieving reports and selecting an eligibility period to searching for subscribers. Finally, the document will address printing and downloading capabilities.

The MA HMO Eligibility List and Capitation Report application is a Web application that allows MA HMO IPAs to view eligibility lists and capitation reports.

This application makes the MA HMO Eligibility List available online, with the ability to view an eligibility list in its entirety, or to make certain selections such as to view all members that have changes since the previous last eligibility list. The last three eligibility lists and a daily current member list is also available. In addition, an address list for current and new members can be viewed for the last three eligibility periods.

The application for capitation reports includes the following: reconciliation, summary, activity count, member counts, capitation by age and gender.

Most of the detail reports can be filtered using search criteria functionality. Summary reports cannot be filtered. Several reports can be downloaded in a .txt format.

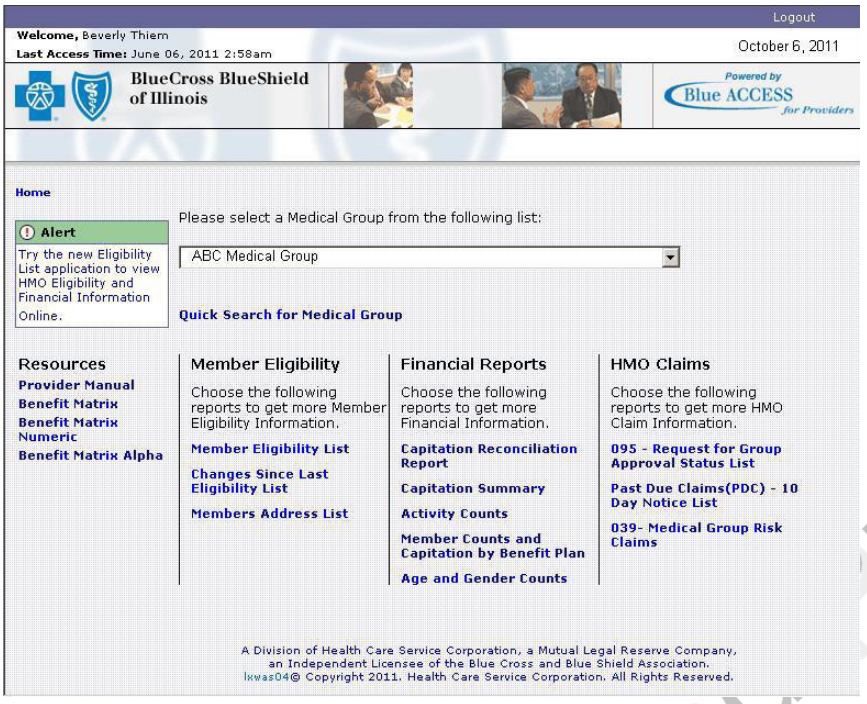
Data definitions can be viewed for all files available for download.

What if I cannot access the Web page?
A security officer has been selected at every IPA. Discuss the issue with your internal security officer first. 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.

Where do I report other problems or if I have questions?
Contact your Provider Network Consultant.

Home Page/General Features



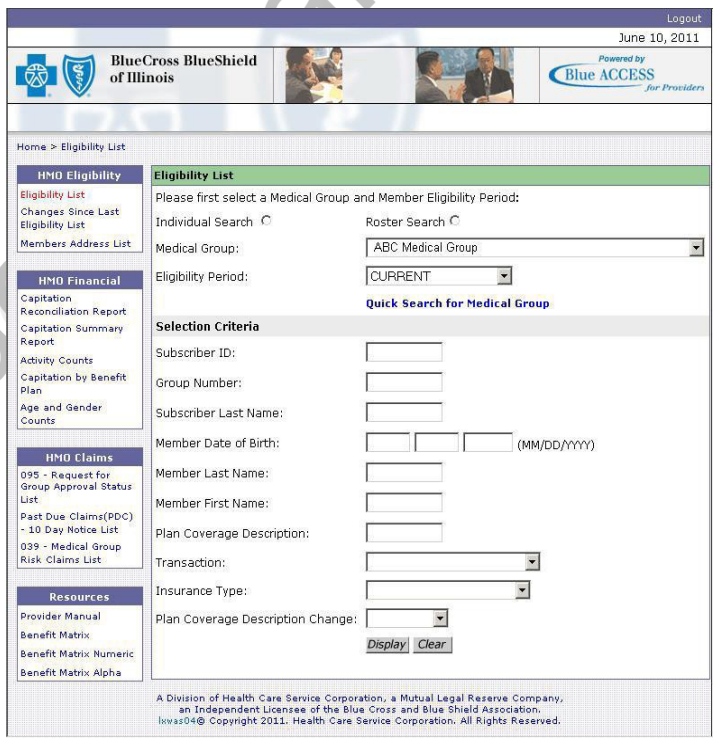
The MA HMO Eligibility List and Capitation Report allows a user to display a variety of reports and searches.

For IPAs with multiple sites, the user can select a particular IPA or choose the report they want to view.

You will only have the ability to view members assigned to your site.

The pages within the site all have a very similar layout that includes a header, side content areas, bread crumbs, a body, vertical navigation/sidebar, a logout button and a footer.

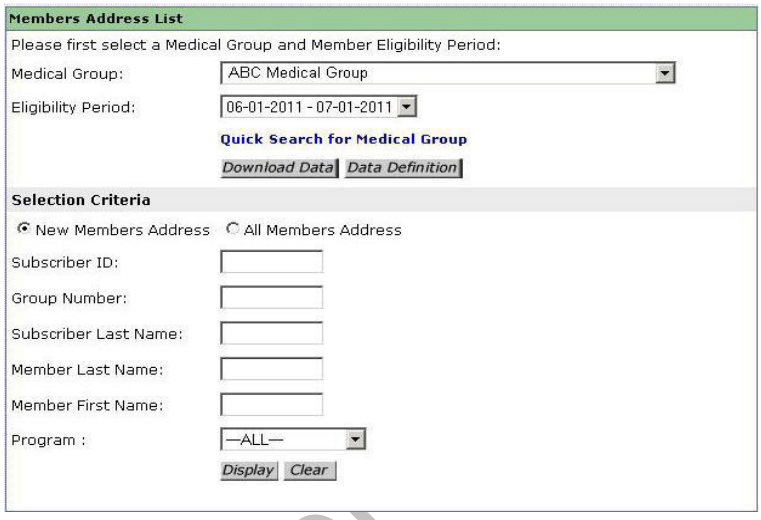
The vertical side bar, the body and the breadcrumbs are the same on every page. They will only be discussed here.

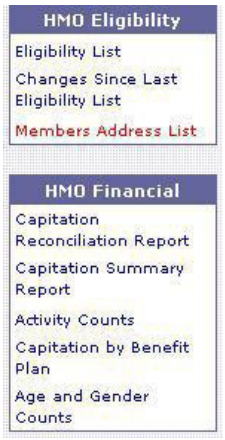


Body

The body is the main section of the Home page. From the body you will choose the report to view, then the eligibility period. You also have the option to refine your search through the options on selection criteria. By clicking on display, the report will be displayed below the body.

On all other pages, the body is the selection criteria form and the results report that is displayed when the user clicks on the 'display' button

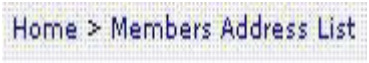




Vertical Navigation/Sidebar Most of the pages, excluding the Home page, on the site include 2 verticals (side) navigation bars, MA HMO Eligibility and MA HMO Financial. This side navigation Contains links to all the reports allowing a user to move from one page on the site to another from their current page.

BreadCrumbs

Breadcrumbs will appear in the header on all pages. The purpose of these is to show the user the navigation they have used to get to their current location of the site and/or to allow them to return to a previous page. The user can click on any of the pages (e.g., home) displayed in the breadcrumbs and they will be returned to that page. For example, if a user clicks on 'home' within the breadcrumbs, the Home page will be displayed.



Logout

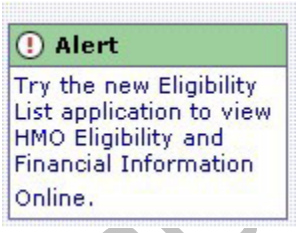
The logout button will appear in the upper right-hand corner of all the pages. This allows the user to log out of the application at any point. Logging out ensures that another user cannot access the member information that the previous user was viewing. It also provides the user with additional advice on other security measures to take.

Site Features and Functions

This section provides an overview of how the site is organized and a description of the available functions.

Alerts

The Alert box is located in the left side of the Home page. The purpose of this information is to provide you with any new messages in a timely fashion. These alerts will be updated periodically, as necessary.



Member Eligibility

The Member Eligibility functions allow a user to view an eligibility list, any changes since last eligibility list and address lists.

A user can view an eligibility list for a specified IPA, (for which they have access rights) for a specified time period. Only the last three periods and the current list can be viewed. The current list includes the most current member information.

Note: On the date the eligibility list runs, no current information will be displayed for at least 24 hours.

Functionality also includes the capability for a user to view member eligibility changes since the last eligibility period.

You can obtain an address list for all existing or just new members for the last three eligibility periods. This report can be downloaded. A data definition report is also available for review.

All eligibility lists can be displayed in full or filtered to only display those records that match the selection criteria that a user defines. Criteria that a user can search on, for all eligibility reports, includes:

- Subscriber ID
- Group number
- Subscriber Last Name
- Member First and Last Name
- Transaction (e.g., Member Add, Member Cancel, Transfer In, Transfer Out, Reinstate, Date of Birth Change, Cancel Date Change, Effective Date Change, Gender Change, Medicare Maintenance) Product.

Financial Reports

Financial Report functionality includes the following reports:

- Capitation Reconciliation Report
- Capitation Summary
- Activity Counts

Capitation Reconciliation reports are available for the last three eligibility periods. This report can be downloaded. The data definition table for the report can also be viewed.

Capitation Summary Reports allows a user to view capitation summary totals for current capitation, retroactive capitation, and total capitation for the last three eligibility periods by product. Totals are broken down by regular capitation and Medicare capitation and by Primary Care Physician (PCP)

Activity Counts Reports display monthly activity counts for the last three eligibility periods by product. The report shows activity counts by transaction type for members with PCP. It breaks the activity counts down by total subscribers, total members, new additions, cancellations, transfers in, transfers out, and reinstates.

Member Counts and Age Counts are currently not supported for the Medicare Advantage products.

Functionality Steps

Logging On

Follow the directions below to log onto the application.

Assumptions

- User is not currently logged on.
- User is a registered user and has a valid User ID and password.

Instructions

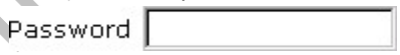
1. Open a web browser.
2. Type the application URL into your browser, as shown below:

   https://providers.hcsc.net/providers/il_login.htm

3. The Login page will be displayed.

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

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



6. Click on the 'Login' button once using your left mouse button.

7. The Home page will be displayed.

Note: The IPA your User ID is associated with will be the default. If your group has multiple sites and your User ID allows access to all sites, then you will be able to view the other IPA sites in the drop-down box.

Your Home page may not display all functions (Member Eligibility, MA HMO Claims and Financial Reports). This is determined at login based on your user rights.

Member Eligibility List Report Functionality

The following includes the steps for using the Member Eligibility List Report.

Eligibility List functionality includes the ability to view an eligibility list for a specified IPA for a specified eligibility period, including the current period. The current period includes the most current data up to the date the user is using the application. These lists can be displayed in full or filtered using the selection criteria.

Assumptions

- User is currently logged on.
- User has access to the IPA they are trying to view the report for

Instructions

1. Select the IPA for which you want to see the Member Eligibility list by selecting that IPA in the drop-down box. This can be selected from the Home page or any other page.

Note: You will only be able to see and select IPAs for which you have access.

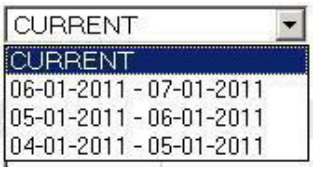
2. Depending which page, you are on:
    a) Home page – select the 'Member Eligibility List' link from the Member Eligibility function area at the bottom left corner of the page.

b) Any Eligibility Report or Financial Report page – select the 'Member Eligibility List' link in the MA HMO Eligibility vertical navigation on the left side of the page.

3. You can repeat or change step 1 at this time, if desired.

4. Using the radio button, select either an individual search or a roster search. If looking up one member, the individual search should be used. The roster search will display all members dependent upon search criteria entered.

5. Select the Eligibility Period for which you want to view the Member Eligibility List.



Note: The Current period includes all data since the last period up until the day proceeding current day

6. To display the full report, continue with step 7. To filter the report based on search criteria, continue with step 11. To display steps for additional functionality, continue with step 16.

To Display Full List

7. Click on the 'Display' button on the bottom of the form.

8. The Member Eligibility list will be displayed for the selected IPA and Eligibility Period. The IPA Number, IPA Name and Eligibility Period will be displayed at the top of the page. The report will indicate how many rows are on the list and which records are displayed on your current page.

   Note: Only 50 records will be displayed on each page.

9. If there are more than 50 rows in your report, you can navigate to the next page by clicking on the 'Next' link on the bottom of the page.

   Note: This link will not appear on the last page of the report, as there are no more results.

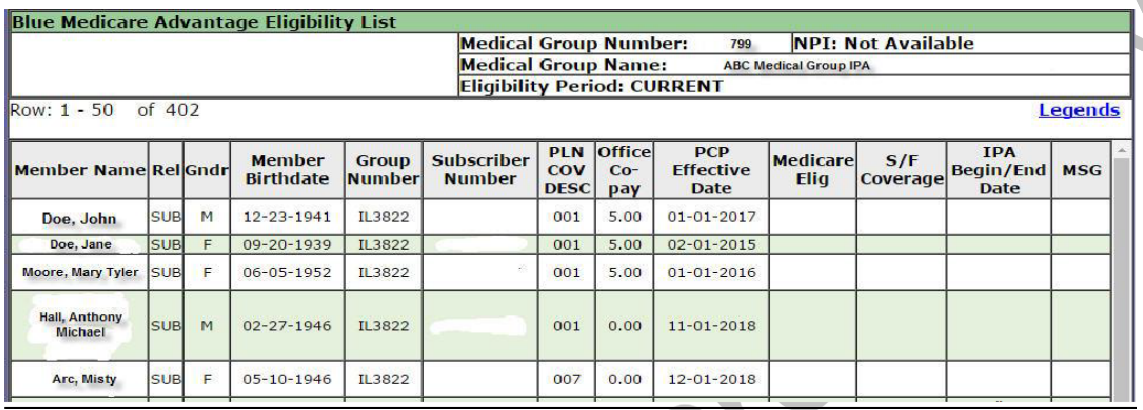
10. The next page of results will be displayed.

To Filter List

11. Filter the list by using the search criteria form fields. You can search using only one search field or by using a combination of multiple (2 to all) fields:
    - Subscriber ID – must enter the full subscriber ID searching for
    - Group Number – must enter the full group number searching for
    - Subscriber Last Name – can enter as much of the name as you know
    - Member Last Name – can enter as much of the name as you know
    - Member First Name – can enter as much of the name as you know
    - Member date of birth – must enter in MM/DD/YYYY format
    - Transaction Code – drop down box, select one of the transaction code IDs
    - Insurance Type – can select one of the categories
    - Plan Coverage Description Change – drop down box, select changed

12. Click on the 'Display' button on the bottom of the form.

13. The Member Eligibility List will be displayed for all records meeting the search criteria entered for the selected IPA and Eligibility Period (*step 11*). The IPA Number, IPA Name, and Eligibility Period will be displayed at the top of the page. The report will indicate how many rows are on the list and which records are displayed on your current page.



Blue Medicare Advantage Eligibility List

Medical Group Number: 799 NPI: Not Available
Medical Group Name: ABC Medical Group IPA
Eligibility Period: CURRENT

Row: 1 - 50 of 402 Legends

Member Name	Rel	Gndr	Member Birthdate	Group Number	Subscriber Number	PLN COV DESC	Office Co-pay	PCP Effective Date	Medicare Elig	S/F Coverage	IPA Begin/End Date	MSG
Doe, John	SUB	M	12-23-1941	IL3822		001	5.00	01-01-2017				
Doe, Jane	SUB	F	09-20-1939	IL3822		001	5.00	02-01-2015				
Moore, Mary Tyler	SUB	F	06-05-1952	IL3822		001	5.00	01-01-2016				
Hall, Anthony Michael	SUB	M	02-27-1946	IL3822		001	0.00	11-01-2018				
Arc, Misty	SUB	F	05-10-1946	IL3822		007	0.00	12-01-2018				

Note: Only 50 records will be displayed on each page. At any point, you can scroll up and re-use the search form, if desired.

14. If there are more than 50 rows in your report, you can navigate to the next page by clicking on the 'Next' link on the bottom of the page.

    Note: This link will not appear on the last page of the report, as there are no more results.

15. The next page of results will be displayed

Additional Functionality

Clearing Search Form

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

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

Changes Since Last Eligibility List Report Functionality

The following includes the steps for using the Changes Since Last Eligibility List Report. This report can be displayed in full or filtered based on search criteria.

Assumptions

- User is currently logged on.
- User has access to the IPA they are trying to view the report for.

Instructions

1. Select the IPA in which you want to see the Changes Since Last Eligibility List for by selecting that IPA in the drop-down box. This can be selected from the Home page or any other page.

Note: You will only be able to see and select IPAs for which you have access.

2. Depending which page, you are on:
   - Home page – select the 'Changes Since Last Eligibility List' link at the bottom left corner of the page.
   - Any Eligibility or Report page – select the 'Changes Since Last Eligibility List' link in the MAHMO Eligibility vertical navigation on the left side of the page.

3. You can repeat or change step 1 at this time, if desired.

4. To display the full report, continue with step 5. To filter the report based on search criteria, continue with step 9. To display steps for additional functionality, continue with step 14.

To Display Full List

5. Click on the **'Display'** button on the bottom of the form.

6. All changes since the last eligibility list (the last full month) will be displayed for the selected IPA. The IPA Number, IPA Name, and Eligibility Period will be displayed at the top of the page. The report will indicate how many rows are on the list and which records are displayed on your current page.

Blue Medicare Advantage Changes Since Last Eligibility List

Medical Group Number:	NPI: Not Available
Medical Group Name:	
Eligibility Period: CURRENT	

Row: 1 - 50 of 402 Legends

Member Name	Rel	Gndr	Member Birthdate	Group Number	Subscriber Number	Benefit Plan	Office Co-pay	PCP Effective Date	Cat	Trans
Doe John	SUB	M	12-23-1941	IL3822		001	5.00	01-01-2017		
Doe, Jane	SUB	F	09-20-1939	IL3822		001	5.00	02-01-2015		
Doe, Jane Anne	SUB	F	06-05-1952	IL3822		001	5.00	01-01-2016		

Note: Only 50 records will be displayed on each page

7. If there are more than 50 rows in your report, you can navigate to the next page by clicking on the **Next** link on the bottom of the page.

   Note: This link will not appear on the last page of the report, as there are no more results.

8. The next page of results will be displayed.

To Filter List

9. Filter the list by using the search criteria form fields. You can search using only one search field or by using a combination of multiple (2 to all) fields:
   - Subscriber ID – must enter the full Subscriber ID searching for
   - Group Number – must enter the full group number searching for
   - Subscriber Last Name – can enter as much of the name as you know
   - Member Last Name – can enter as much of the name as you know
   - Member First Name – can enter as much of the name as you know

- Transaction – can select one of the transaction codes
- Category – can select one of the categories
- Program – can select one of the products

10. Click on the 'Display' button on the bottom of the form.

11. All the changes since the last eligibility list that meet the search criteria for the selected IPA and Eligibility Period are displayed. The IPA Number, IPA Name, and Eligibility Period will be displayed at the top of the page. The report will indicate how many rows are on the list and which records are displayed on your current page.

Blue Medicare Advantage Changes Since Last Eligibility List

	Medical Group Number:	NPI: Not Available
	Medical Group Name:	
	Eligibility Period: CURRENT	

Row: 1 - 50 of 402 Legends

Member Name	Rel	Gndr	Member Birthdate	Group Number	Subscriber Number	Benefit Plan	Office Co-pay	PCP Effective Date	Cat	Trans
Doe John	SUB	M	12-23-1941	IL3822		001	5.00	01-01-2017		
Doe, Jane	SUB	F	09-20-1939	IL3822		001	5.00	02-01-2015		
Doe, Jane Anne	SUB	F	06-05-1952	IL3822		001	5.00	01-01-2016		

Note: Only 50 records will be displayed on each page. At any point, you can scroll up and re-use the search form, if desired.

12. If there are more than 50 rows in your report, you can navigate to the next page by clicking on the 'Next' link on the bottom of the page.

Note: This link will not appear on the last page of the report, as there are no more results.

13. The next page of results will be displayed.

Additional Functionality

Clearing Search For

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

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

Members Address List Report Functionality

The following includes the steps for using the Members Address List.

Members Address List functionality includes the ability to view all members' or only new members' addresses for the last three eligibility periods. This report can be downloaded. A data definition report is also available.

Assumptions

- User is currently logged on.
- User has access to the IPA they are trying to view the report for.

Instructions

1. Select the IPA in which you want to see the new members addresses for by selecting that IPA in the drop-down box. This can be selected from the Home page or any other page.

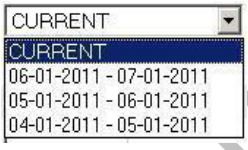
Note: You will only be able to see and select IPAs for which you have access.

2. Depending on which page you are on:
   a) Home page – select the 'Members Address List' link from the Member Eligibility function area at the bottom left corner of the page.
   b) Any Eligibility Report or Financial Report page – select the 'Members Address List' link from the MA HMO Eligibility vertical navigation on the left side of the page.

3. You can repeat or change step 1 at this time, if desired.

4. Using the radio button, select the address list for either new members or all members.

5. Select the Eligibility Period for which you want to obtain the new members addresses.



6. To display the full list, continue with step 7. To filter the list based on search criteria, continue with step 11. To download the list, continue with step 16. To display steps for additional functionality, continue to step 23.

To Display the Full List

7. Click on the 'Display' button on the bottom of the form.

8. The addresses of all new members for the selected IPA and Eligibility Period will be displayed. The IPA Number, IPA Name and Eligibility Period will be displayed at the top of the page. The report will indicate how many rows are on the list and which records are displayed on your current page.

Blue Medicare Advantage Address List Report

	Medical Group Number: Site #	**NPI: Not Available**
	Medical Group Name: ABC Medical Group IPA	
	Eligibility Period: 01-01-2019 to 02-01-2019	

Row: 1 - 14 of 14 Legend

Member Name	Street	City	State	Zip	Group	Subscriber	Address Type
Doe, John	123 Elm St	SKOKIE	IL	60076	IL3822	8999999999	
Doe, Jane	123 Addison St	CHICAGO	IL	60630	IL3822	8999999999	
Doe, John III	1234 Pleasamt Drive	CHICAGO	IL	60630	IL3822	8999999999	

Note: Only 50 records will be displayed on each page.

9. If there are more than 50 rows in your report, you can navigate to the next page by clicking on the 'Next' link on the bottom of the page.

Note: This link will not appear on the last page of the report, as there are no more results.

10. The next page of results will be displayed.

To Filter List

11. Filter the list by using the search criteria form fields. You can search using only one search field or by using a combination of multiple (2 to all) fields:
    - Subscriber ID – must enter the full Subscriber ID searching for
    - Group Number – must enter the full group number searching for
    - Subscriber Last Name – can enter as much of the name as you know
    - Member Last Name – can enter as much of the name as you know
    - Member First Name – can enter as much of the name as you know
    - Program – drop down box, make selection

12. Click on the 'Display' button on the bottom of the form.

13. All the members' addresses for the eligibility list that meet the search criteria (step 11) for the selected IPA and Eligibility Period will be displayed. The IPA Number, IPA Name, and Eligibility Period will be displayed at the top of the page. The report will indicate how many rows are on the list and which records are displayed on your current page.

Blue Medicare Advantage Address List Report

Medical Group Number: Site #	NPI: Not Available
Medical Group Name: ABC Medical Group IPA	
Eligibility Period: 01-01-2019 to 02-01-2019	

Row: 1 - 14 of 14 Legend

Member Name	Street	City	State	Zip	Group	Subscriber	Address Type
Doe, John	123 Elm St	SKOKIE	IL	60076	IL3822	8999999999	
Doe, Jane	123 Addison St	CHICAGO	IL	60630	IL3822	8999999999	
Doe, John III	1234 Pleasamt Drive	CHICAGO	IL	60630	IL3822	8999999999	

Note: Only 50 records will be displayed on each page. At any point, you can scroll up and re-use the search form, if desired.

14. If there are more than 50 rows in your report, you can navigate to the next page by clicking on the 'Next' link on the bottom of the page.

Note: This link will not appear on the last page of the report, as there are no more results.

15. The next page of results will be displayed.

To Download Report

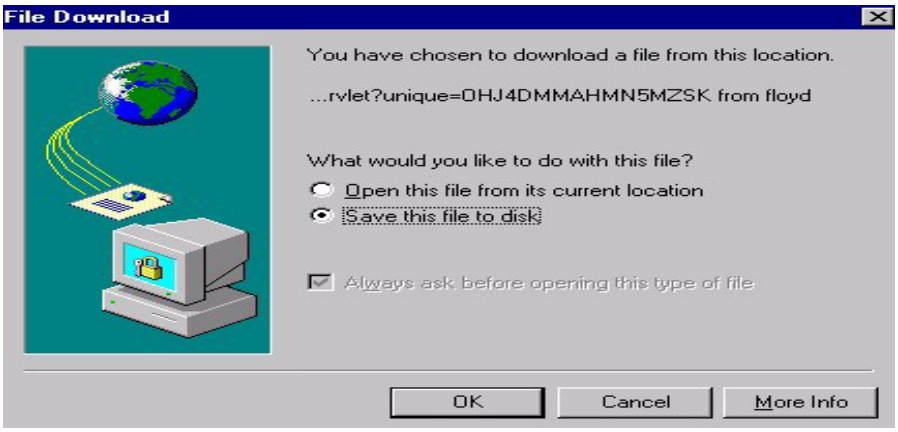
16. You can download (the full list) by clicking on the 'Download Data' button.

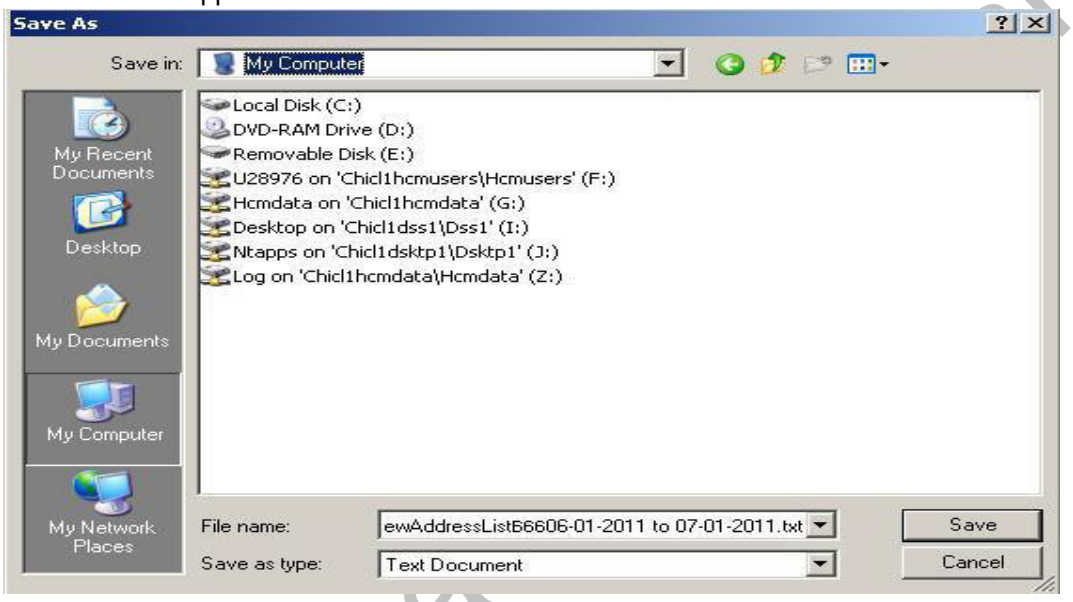
17. Depending on your browser, you will receive a message box.

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

    Click on the 'Save this File to Disk' radio button and then 'OK'.



18. 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.

19. 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.

20. Clink on the 'Save' button.

21. The file will be saved in a .txt format to the location selected.

Additional Functionality

*Data De*inition Table*

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

Data Definition

23. The Data Definition table will be displayed in a pop-up window. This page can also be printed

Field Name	Data Type	Length	Description
PROV_ID	Number	3	Contracting Entity Number
PROV_SEQ_NBR	Number	3	Medical Group Number
MEM_NM	VarChar	40	Member Full Name
STREET	VarChar	85	Member Full Street Address
CTY_NM	Char	25	Member City
ST_CD	Char	2	Member State
ZIP_CD	Char	9	Member Zip Code
GRP_NBR	Char	6	Group Number
SUB_ID_NBR	Char	12	Subscriber Number (SSN)
ELIG_PER_FR_DT	Char	10	Eligibility List From Date (MM-DD-YYYY)
ELIG_PER_TO_DT	Char	10	Eligibility List To Date (MM-DD-YYYY)
IPA_NPI_NBR	VarChar	10	Medical Group National Provider Identifier
ADDR_TYP	Char	2	Member Address Type

Note: For Varchar Field, Length Listed is the Maximum Value.

24. 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.
    

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

Clearing Search Form

25. To clear you search criteria, at any time, click on the 'Clear' button.
    

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

Capitation Reconciliation Report Functionality

The following includes the steps for using the Capitation Reconciliation Report.

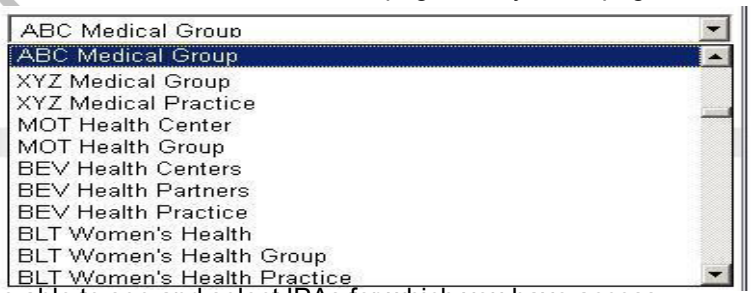
Capitation Reconciliation Report functionality includes the ability to view the capitation reconciliation details for a selected IPA for one of the last three eligibility periods. These reports can be downloaded. Downloaded data includes all information from Eligibility Report, Capitation Reconciliation Report and the Member Address Report.

Assumptions

- User is currently logged on.
- User has access to the IPA they are trying to view the report for.
- User has access to financial reports.

Instructions

1. Select the IPA in which you want to see the Capitation Reconciliation Report for by selecting that IPA in the drop-down box. This can be selected from the Home page or any other page.



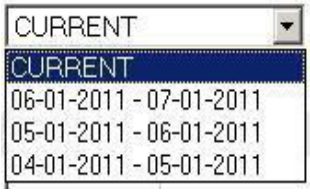
Note: You will only be able to see and select IPAs for which you have access

2. Depending on which page you are on:
    a) Home page – select the 'Capitation Reconciliation Report' link from the Financial Reports function area at the bottom left corner of the page.

b) Any Eligibility Report or Financial Report page – select the 'Capitation Reconciliation Report' link from the MA HMO Financial vertical navigation on the left side of the page.

3. You can repeat or change step 1 at this time, if desired

4. Select the Eligibility Period for which you want to view the capitation reconciliation details.



5. To display the full list, continue with step 6. To filter the list based on search criteria, continue with step 10. To download the list, continue with step 15. To display steps for additional functionally, continue to step 22.

To Display the Full List

6. Click on the 'Display' button on the bottom of the form.

7. The capitation reconciliation details for the selected IPA and Eligibility Period will be displayed. The IPA Number, IPA Name and Eligibility Period will be displayed at the top of the page. The report will indicate how many rows are on the list and which records are displayed on your current page.

Note:

- Only 50 records will be displayed on each page.
- To view a table with the legend codes for the change reason column, click on the 'Legends' link that appears to the right below the IPA identifiers.
- The codes will be displayed in a pop-up window.
- To close the code pop-up window, click on the 'x' button at the top of the window.

Blue Medicare Advantage Capitation Reconciliation Report

Medical Group Number: 799	NPI: Not Available
Medical Group Name:	
Eligibility Period: 01-01-2019 to 02-01-2019	

Row: 1 - 50 of 461 Legends

Member Name	Subscriber ID Number	Age	Gndr	Benefit Plan	PCP Effective Date	Change Reason	MG Effective Date	MG Capitation Retro Current		Total Capitation
Doe, John	8999999999	77	M	001	01-01-2017		01-01-2017		$320.72	$320.72
Doe, Jane	8999999999	68	F	001	02-01-2017	P-I	02-01-2017			$0.00
Doe, Dereck	8999999999	68	M	001	03-01-2017	P-I	03-01-2017			$0.00

8. If there are more than 50 rows in your report, you can navigate to the next page by clicking on the 'Next Page' link on the bottom of the page.

Note: This link will not appear on the last page of the report, as there are no more results.

9. The next page of results will be displayed.

To Filter List

10. Filter the list by using the search criteria form fields. You can search using only one search field orby using a combination of multiple (2 to all) fields:
    - Subscriber ID – must enter the full Subscriber ID searching for
    - Group Number – must enter the full group number searching for
    - Subscriber Last Name – can enter as much of the name as you know
    - Member Last Name – can enter as much of the name as you know
    - Member First Name – can enter as much of the name as you know
    - Transaction – can select one of the transaction codes
    - Category – can select one of the categories
    - Product – can select one of the products

11. Click on the 'Display' button on the bottom of the form.

    Display

12. All the capitation reconciliation detail records that meet the search criteria (step 10) for the selected IPA and Eligibility Period will be displayed. The IPA Number, IPA Name and Eligibility Period will be displayed at the top of the page. The report will indicate how many rows are on the list and which records are displayed on your current page.

Blue Medicare Advantage Changes Since Last Eligibility List

Medical Group Number:	NPI: Not Available
Medical Group Name:	
Eligibility Period: CURRENT	

Row: 1 - 50 of 402 Legends

Member Name	Rel	Gndr	Member Birthdate	Group Number	Subscriber Number	Benefit Plan	Office Co-pay	PCP Effective Date	Cat	Trans
Doe John	SUB	M	12-23-1941	IL3822		001	5.00	01-01-2017		
Doe, Jane	SUB	F	09-20-1939	IL3822		001	5.00	02-01-2015		
Doe, Jane Anne	SUB	F	06-05-1952	IL3822		001	5.00	01-01-2016		

Note: Only 50 records will be displayed on each page. At any point, you can scroll up and reuse the search form, if desired.

13. If there are more than 50 rows in your report, you can navigate to the next page by clicking on the 'Next Page' link on the bottom of the page.

    Note: This link will not appear on the last page of the report, as there are no more results.

14. The next page of results will be displayed.

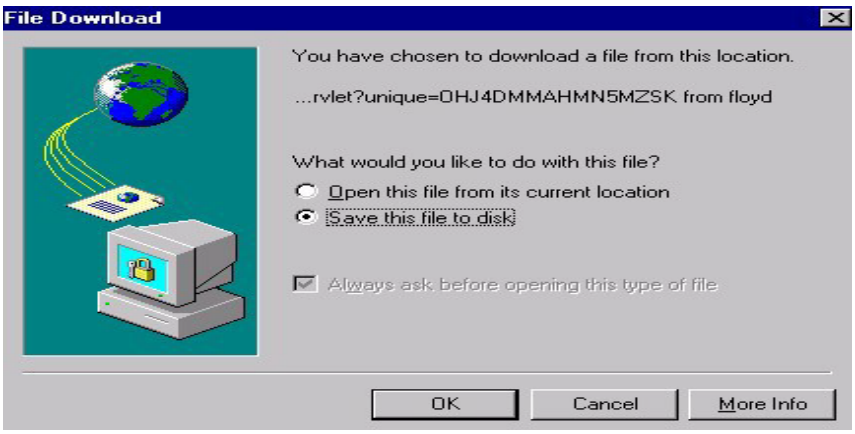
To Download Report

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

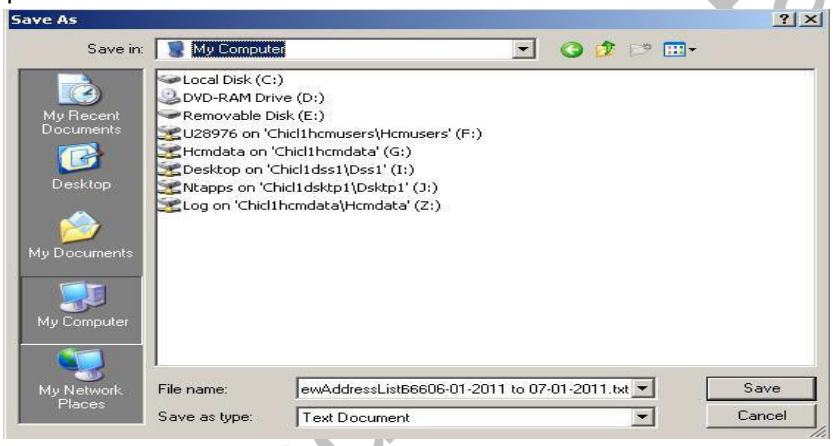
    Download Data

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

    Internet Explorer: You will probably receive a File Download Dialog Box
    Click on the 'Save this File to Disk' radio button and click on 'OK'.



17. The Save As window will appear.



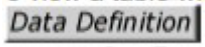
Note: The File Name defaults to the Report Name, IPA Number, and Eligibility Period. However, you can change this if you want.

18. 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.
19. Click on the 'Save' button.
20. The file will be saved in a .txt format to the location selected.

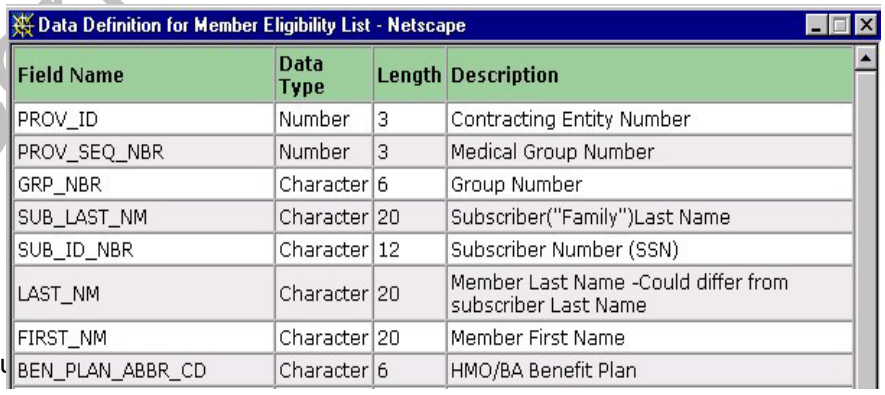
Additional Functionality

Data De

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



22. 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

23. You

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

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

Clearing Search Form

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

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

Capitation Summary Report Functionality

The following includes the steps for using the Capitation Summary Report.

Capitation Summary Report functionality includes the ability to view the capitation summary totals for one of the last three eligibility periods for a selected IPA. Summary totals include current capitation, retroactive capitation, and total capitation by product. Totals are broken down by regular capitation and Medicare capitation by PCP.

Assumptions

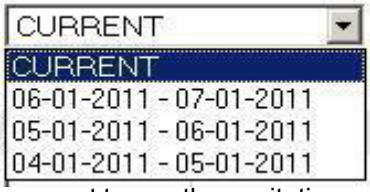
- User is currently logged on.
- User has access to the IPA they are trying to view the report for.
- User has access to financial reports.

Instructions

1. Select the IPA in which you want to see the capitation summary for by selecting that IPA in the drop-down box. This can be selected from the Home page or any other page.

Note: You will only be able to see and select IPAs for which you have access.

2. Depending on which page you are on:
   a) Home page – select the 'Capitation Summary' link from the Financial Reports function area at the bottom left corner of the page.
   b) Any Eligibility Report or Financial Report page – select the 'Capitation Summary Report' link from the Financial vertical navigation on the left side of the page.
3. You can repeat or change step 1 at this time, if desired.
4. Select the Eligibility Period for which you want to view the capitation summary.



5. Select the product you want to see the capitation summary for by clicking on the program's radio button.
6. Click on the 'Display' button on the bottom of the form.

7. The capitation summary for the selected IPA and Eligibility Period will be displayed. The IPA Number, IPA Name, and Eligibility Period will be displayed at the top of the page.

Display

Blue Medicare Advantage Capitation Summary		
	Medical Group Number:	NPI: Not Available
	Medical Group Name:	
	Eligibility Period: 01-01-2019 to 02-01-2019	

Medicare Advantage		MG
Current Capitation	Current Capitation	$0.00
	Total Current Capitation	**$176,470.05**
Retroactive Capitation	Regular Retroactive	$0.00
	Total Retroactive Capitation	**($99.03)**
Total Capitation	Total Regular Capitation	$0.00
	Total Capitation	**$176,371.02**

Explanation of Eligibility List Codes on the Capitation Summary Report

1. Current Capitation – The amount of monthly capitation paid for members assigned to IPA
2. Retroactive Capitation – The amount of retroactive monthly capitation paid or deducted for member activity with a prior month effective date
3. Total Capitation – The amount of total monthly capitation for IPA MA HMO members

Activity Counts Report Functionality

The following includes the steps for using the Activity Counts Report.

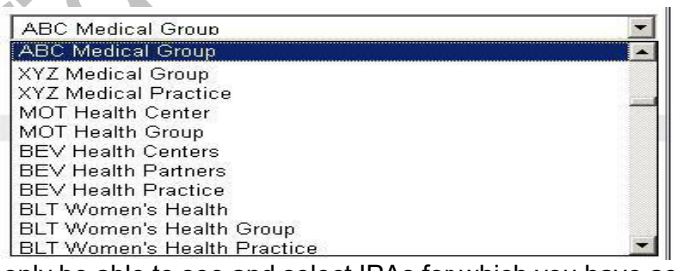
Activity Count Report functionality includes the ability to display activity counts for a selected IPA for the last three eligibility periods by product. The report shows activity counts by transaction type for Members with PCP and WPHCP, Members with PCP only, Members with WPHCP only, Medicare Primary PCP and WPHCP, Medicare Primary PCP only, Medicare Primary WPHCP only and total for all. It breaks the activity counts down by total subscribers, total dependents, total members, new additions, cancellations, transfers in, transfers out and reinstates.

Assumptions

- User is currently logged on.
- User has access to the IPA they are trying to view the report for.
- User has access to financial reports.

Instructions

1. Select the IPA in which you want to see the activity counts for by selecting that IPA in the drop-down box. This can be selected from the Home page or any other page.



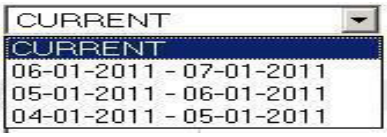
Note: You will only be able to see and select IPAs for which you have access.

2. Depending on which page you are on:
   a) Home page – select the 'Activity Counts' link from the Financial Reports function area at the bottom left corner of the page.

b) Any Eligibility Report or Financial Report page – select the 'Activity Counts' link from the MAHMO Financial vertical navigation on the left side of the page.

3. You can repeat or change step 1 at this time, if desired.

4. Select the Eligibility Period for which you want to view the activity counts.



5. Select the product you want to see the activity counts for by clicking on the program's radio button.

6. Click on the 'Display' button on the bottom of the form.

7. The activity counts for the selected IPA and Eligibility Period will be displayed. The IPA Number, IPA Name and Eligibility Period will be displayed at the top of the page.

. 

Blue Medicare Advantage Activity Counts				
	Medical Group Number:		NPI: Not Available	
	Medical Group Name:			
	Eligibility Period: 01-01-2019 to 02-01-2019			
	Medicare Advantage	Members	Medicare Primary Members	Totals
TOTAL SUBSCRIBERS	0	398	398	
TOTAL DEPENDENTS	0	0	0	
TOTAL MEMBERS	0	398	398	
NEW ADDITIONS	0	12	12	
CANCELLATION	0	59	59	
TRANSFER IN	0	2	2	
TRANSFER OUT	0	2	2	

Explanation of Eligibility List Codes on the Activity Counts Page

1. Total Subscribers – Total number of subscribers effective with IPA for each category for the month
2. Total Dependents – Not a current function for Medicare Advantage
3. Total Members – Total active members.
4. New Additions – Total number of new additions with IPA for each category PCP
5. Cancellations – Total number of cancellations with IPA for each category effective for current month
6. Transfer In – Total number of members transferred in from another IPA's effective for the current month
7. Transfer Out – Total number of members transferred to another IPA for the current month
8. Reinstates – Total number of members reinstated effective for the current month

Procedure If a Member Does Not Appear on the Eligibility List

Occasionally, an eligible member will not appear on the Eligibility List. This can be for a variety of reasons. If this occurs, the IPA should do the following:

1. Verify the subscriber's name. The member's surname may be different. Look on the list under the subscriber's last name.
2. Check the online membership system. Or if applicable call the Customer Service number on the back of the

If membership is verified, the IPA should perform services for the member and should check the next month's Eligibility List to verify capitation was received for the member. (See Retroactive Capitation in the Payment/Compensation to the IPA Section of this manual) If it is not, the IPA should submit a request for Manual

If membership cannot be verified, the IPA should:

1. Explain this to the member and have the member check with Customer Service number on the back of their ID card to verify coverage; and
2. The IPA should either:
   a) Perform services and charge the member at the time of service. Refund the money to the member if he/she appears on the Eligibility List, or
   b) Perform services and bill the member if he/she does not appear on the next Eligibility List.

When the Member Has a Question About a Membership Issue

- If the member loses or needs a new ID card, the member should call the Customer Service number located on the back of the ID card.
- If the member wants to change IPAs or change their Primary Care Physician, the member should call the Customer Service number located on the back of the ID card. If the member calls by the end of the month, the member will become effective the first of the next month. For example, if the member calls on March31, the member will be effective on April 1 with the selected IPA.

Unassigned Members

There are occasions where a member will be eligible with the MA HMO but does not have a valid IPA assignment.

The member will not receive an ID Card. The member will receive a package of information requesting them to choose an IPA. No ID card will be issued until an IPA has been chosen.

If a member does not choose an IPA within 30 days, the MA HMO will assign the subscriber (and dependents, if applicable) to an IPA based on geographic location. If a member wishes to change the IPA assignment, the member should call the Customer Service number on the back of the ID card.

IPA Request for Member Transfer (Ask Out Policy)

The IPA has the right to request that the MA HMO remove a member when that member disrupts their normal business practice(s). An IPA's request for a member transfer is viewed by the MA HMO as a significant and serious event. The consequences of a member's transfer will mean the disruption of that member's care and it is important that a documented process be carefully followed. The final decision is made by the MA HMO to involuntarily transfer a member out of an IPA.

Refer to the MA HMO Policy and Procedure Section on the BCBSIL website, Policies and Procedures, for the full process on requesting that a member be transferred out of the IPA.

Transition Policy for New and Prospective Members

Please refer to the MA HMO Policy and Procedure Section on the BCBSIL Provider website.

Transition Process for Current Members

When a provider leaves an IPA, the IPA must notify the HMO with a 90-day prior notification.

Retroactive IPA Member Changes

The HMOs of Blue Cross and Blue Shield of Illinois (HMO) will provide established guidelines for appropriate HMO staff to facilitate all retroactive Medical Group/Individual Practice Association or Physician Hospital Organization (hereinafter the "IPAs"), Primary Care Physicians (PCPs) change requests from existing MA HMO members

Please refer to the MA HMO Policy and Procedure Section **GPD IL MA 01.20** on the BCBSIL Provider website.

Verifying Membership

Call the Customer Service number located on the back of the ID card. Contact your Provider Network Consultant for additional information.

Claim Processing Procedures

- Claims that are the financial liability of the IPA should be submitted directly to the appropriate IPA for payment
- Claims that are the financial liability of the HMO should be submitted to Blue Cross and Blue Shield of Illinois (BCBSIL).
- The member's selected IPA must adjudicate claims received and offer the following dispositions:
- **Group Approved (GA) –** The service was managed by one of the IPA's physicians or referred by an IPA physician.
- **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 is required to identify 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 current partial/global risk Division of Financial Responsibility (DOFR) Exhibit of the Medical Service Agreement (MSA) and detailed Scope of Benefits should be used to determine which services are the financial responsibility of the HMO and the financial responsibility of the IPA.
- Participating Providers may not bill HMO for health care services rendered to themselves or their immediate family members, or designate themselves as a primary care physician, for any purpose, for themselves or their Immediate Family Members. An "Immediate Family Member" is defined as: (i) current spouse; (ii) eligible domestic partner; (iii) parents and step-parents of the spouse or domestic partner; (iv) children and grandchildren (biological, adopted or other legally placed children) of the spouse or domestic partner; and (v) siblings (including biological, adopted, step, half or other legally placed children) of the spouse or domestic partner. HMO will not process any claims for services, nor make payment for any claims for services, rendered by a Participating Provider to him or herself, or to his or her Immediate Family Members. If HMO determines that a benefit was paid in error, HMO has the right to request and receive a refund of the payment from the Participating Provider. For purposes of this Section,
  "Participating Provider" means a licensed health care provider under the Illinois Medical Practice Act who is contracted with the IPA for the provision of covered services to members in accordance with the terms of the Medical Service Agreement.

HMO Claims Address

The IPA should submit all HMO risk and non-group approved claims to the following address:

Blue Cross Medicare Advantage
c/o Provider Services
P.O. Box 3686 Scranton, PA. 18505

BCBSIL may automatically cancel a Provider Record ID that does not have any claim dates of service within a 24 month time period. Terming of the Provider Record ID might also result in termination of associated networks. Provider record IDs are specific to billing/rendering NPIs and Tax Identification Numbers.

Claim Disputes

You may dispute a claims payment decision by requesting a claim review. If you have a question regarding claims disputes, please contact 877-774-8592.

Process Used to Recover Overpayments on Claims

The IPA shall provide notice to the HMO of any overpayment(s) identified by the IPA, including duplicate payments, within 10 calendar days of identifying such overpayment, and unless otherwise instructed by the HMO in writing, the IPA shall refund any amounts due to the HMO within 30 calendar days of identifying such overpayment. The HMO may recover the amounts owed by way of offset or recoupment from current or future amounts due from the HMO to the IPA.

Coding Related Updates

Provider acknowledges and agrees that BCBSIL may apply claim editing rules or processes, in accordance with correct coding guidelines and other industry-standard methodologies, including, but not limited to, CMS, CPT, **Relay Health,** and **Cotiviti** coding process edits and rules.

Balance Billing

An important protection for members when they obtain plan-covered services in a Medicare Advantage Plan is that they do not pay more than plan-allowed cost sharing.

You may not bill a member for a **non-covered** service unless:

- You have informed the member in advance that the service is not covered, and
- The member has acknowledged in writing that services are not covered in advance of receiving services, and
- The member has agreed in writing to pay for the non-covered services in advance of receiving services.

MA HMO Responsibility Claims

The HMO must obtain Group Approval status on all HMO responsibility claims from the IPA. There are three methods:

- The HMO will send the claim to the IPA for approval status. The claims should be stamped with the approved HMO stamp using blue or black ink only; all fields must be completed and returned to the HMO within five working days of receipt. (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.
    - Group approved claims will then be processed by the HMO according to the member's benefit plan. Non- Group Approved claims will be denied and an Explanation of Benefits will be sent to the provider and member.
    - The HMO reserves the right to review Non-Group Approved claims and make final determination.

MA HMO-POS Responsibility Claims

For best member benefit and lowest out of pocket cost shares The HMO must obtain Group Approval status on all HMO responsibility claims from the IPA and follow the guidelines as listed above in MA HMO Responsibility Claims section.

With the MA HMO-POS Plan(s) Members may utilize their POS Benefit and seek services from a BCBSIL contracted provider without a referral but will be responsible for higher cost shares as dictated by their benefit plan and EOC. The IPA is fiscally responsible for paying the difference between the CMS allowed amount and the members designated cost share for their plan at the out-of-network (OON) benefit level.

Sample IPA Approval Stamp

HMOI IPA #

Date Received
(By IPA)

GA ❑

NGA ❑

Date Returned

Name or Initial

- The HMO must make available to the IPA the daily 095 - Request for Group Approval Status Report via the secured provider portal, Blue Access for Providers. Each IPA user must have a secure sign on. The Provider Network Consultant should be contacted to facilitate obtaining access. If technical assistance is needed after the sign on is received, contact our Blue Access® Internet Help Desk at 888-706-0583.

- The IPA will indicate approval status for each claim listed in the report (refer to training materials, which start on page 4). The IPA's response must be made within 14 calendar days of the Report Date. If the response is not received within 14 days, the HMO will assume the claim is group approved and process according to the members benefits. 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.

Blue Access for Providers (BAP)- https://providers.hcsc.net/providers/il_login.htm

The IPA should download the data regularly for historical documentation purposes. The data definitions are located on the Web.

Request for Group Approval Status Report Training Materials

The following includes the steps to access the section titled HMO Claims, Follow the directions below to access the report and the application's functionality.

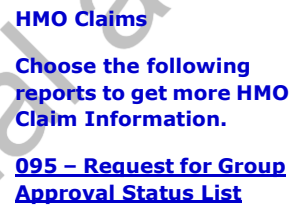
HMO Claims functionality includes the ability to view and respond with the group approval status of claims that are the financial risk of Blue Cross Medicare Advantage HMO. These reports can be downloaded. The data definitions are in this section. Downloaded data can include open claims, as well as claims that have been completed.

Assumptions:

- User is currently logged on
- User has access to the IPA
- User has access to the claim's reports

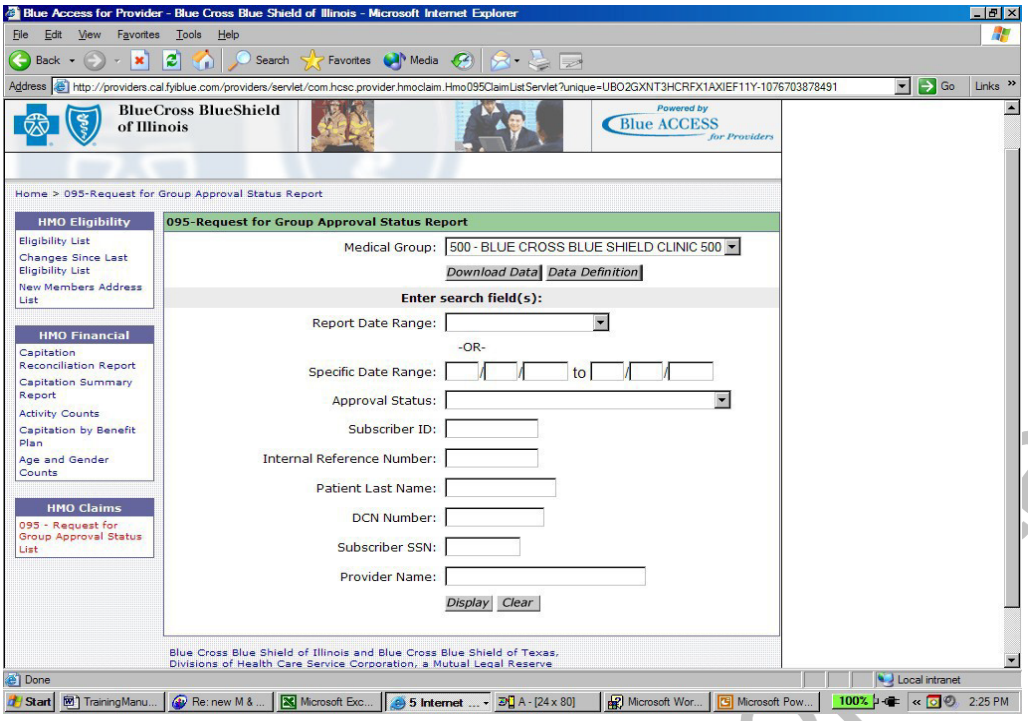
Instructions:

1. Select **HMO Claims**
2. Click on 095-Request for Group Approval Status Report

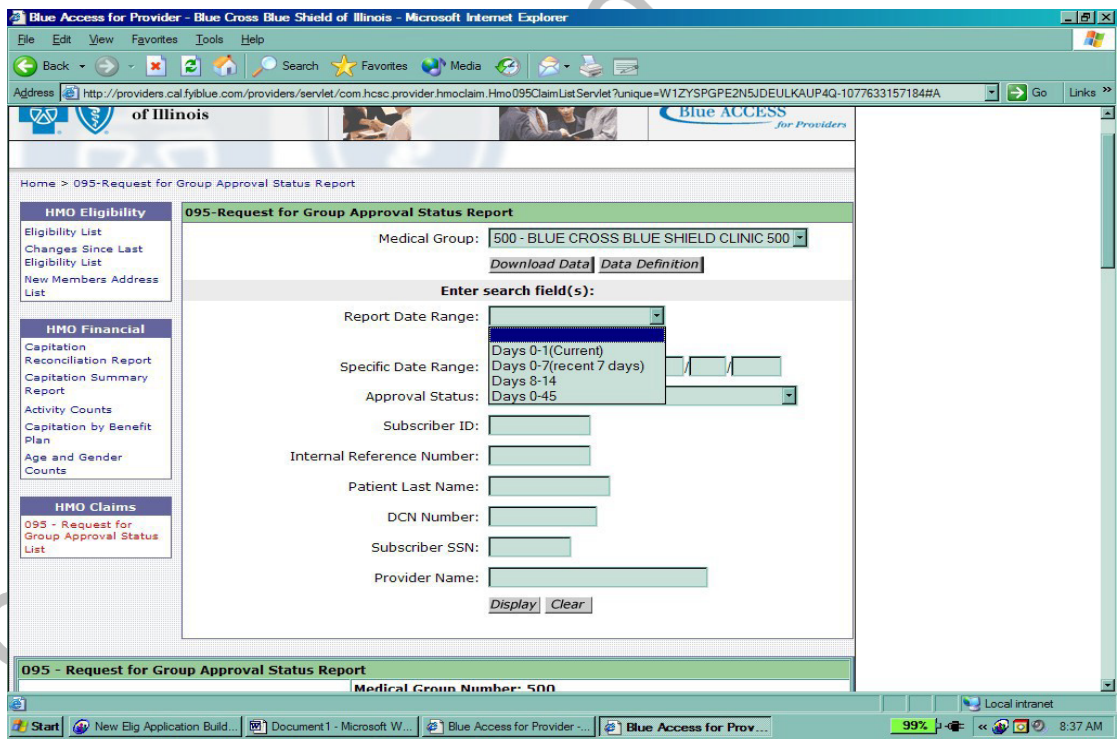


3. Select an IPA, if you have access to more than one, in the dropdown box.

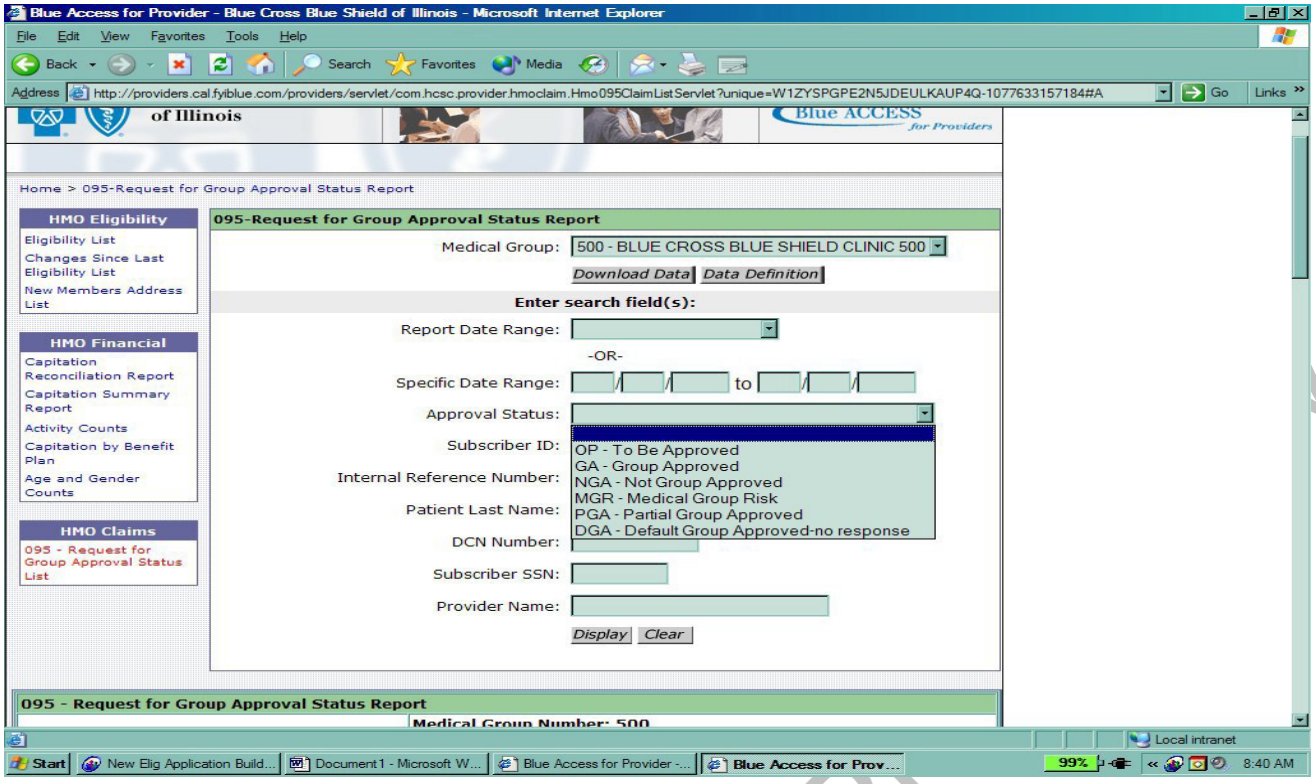
- You should arrive at this search window. You have multiple options to search for open or closed claims. To see the entire report, you may click on **Display.**



- Alternatively, you may enter a search argument such as a Report Date Range by clicking on the dropdown box under" Report Date Range", select the range and then click **Display** to see the list.



- You may also enter a search argument in the Approval Status dropdown, 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.



- 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.

095-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

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

The following fields are “open” and are 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. The field is freeform, alpha/numeric, up to 13 characters.

☐ **GA – Group Approved**

Check the box

☐ **NGA – Not Group Approved**
Check the box

☐ **MGR – Med Group Risk**

1. 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 Fill.
2. The claim must be paid timely by the IPA.

Comments:

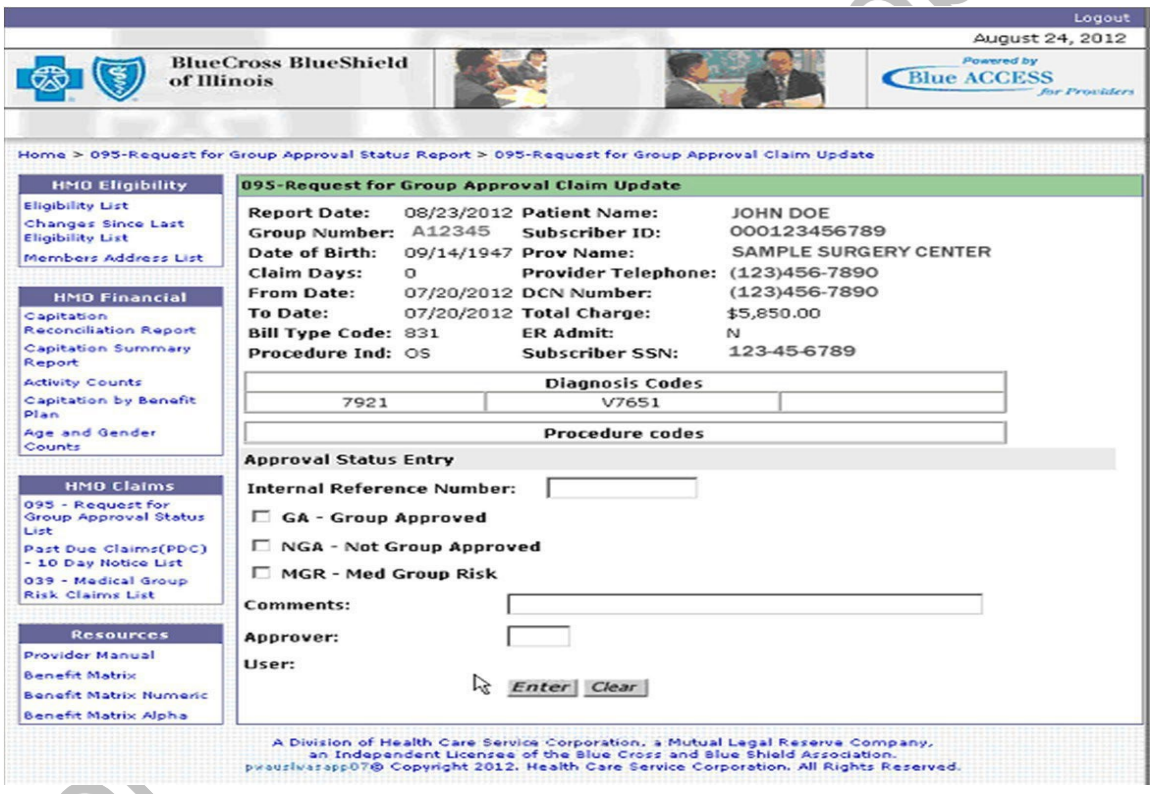
- Enter up to 200 alpha/numeric characters.
- To be used when you want to send us information.

Approver:

- Three alpha/numeric characters.
- For IPA internal use to document who submitted group approval status.

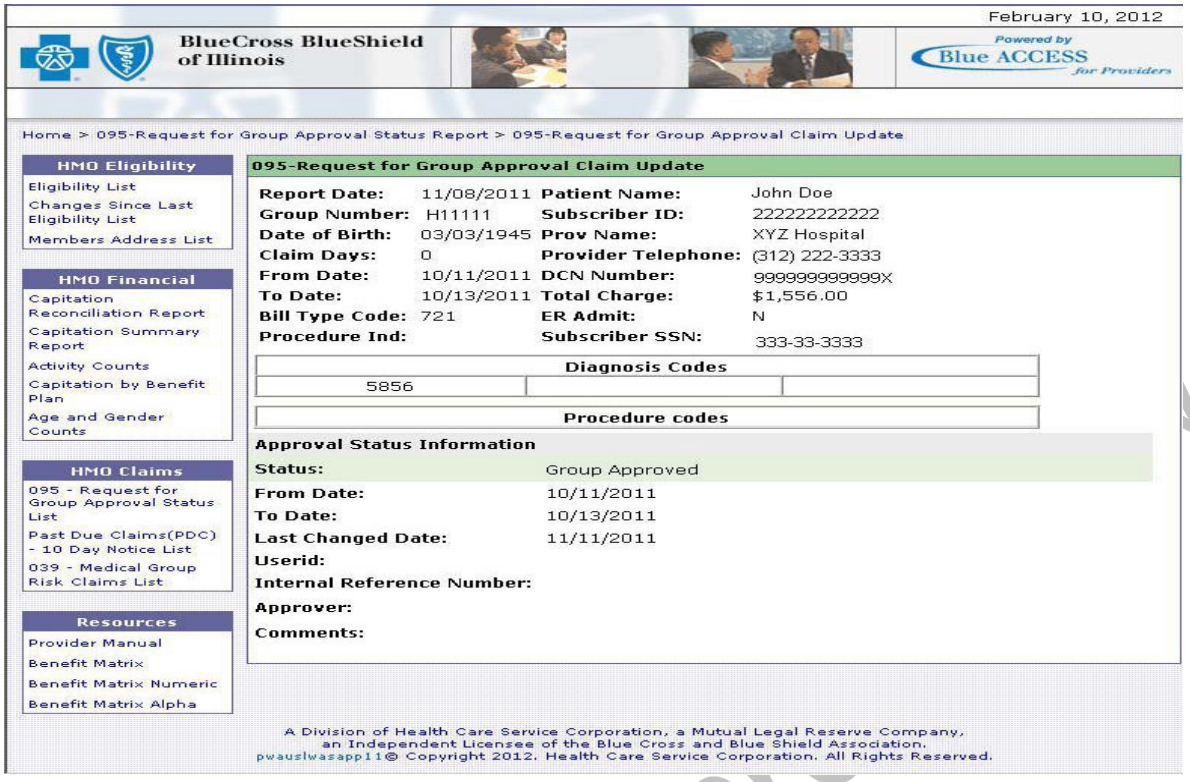
User:

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



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

- 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.



Trouble Shooting Tips

What if I make a mistake?

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

1. Open the claim in question on the Web
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, phone number and the name of your IPA
7. Fax to 855-674-9192. Fax only one claim at a time.

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.

What if I can't access the Web page?

A security officer has been assigned to every IPA. Discuss your problem first with your internal security officer. If you continue to have a problem, call the BCBSIL Internet Help Desk at 888-706-0583 for assistance.

What If I forgot my password or my sign on?

Call the BCBSIL Internet Help Desk at 888-706-0583.

What if BCBSIL is having technical problems and the Web page is not available for us to work our claims?
If we are experiencing problems and the Web is unavailable for more than a few hours, we will not download and pay claims that will become 14 days old at the end of the day.
Note: It is not advised to wait until the 14th day to work your claims.

What if I need a copy of the claim?

IPAs requesting a copy of the claim may contact Customer Service at 877-774-8592.

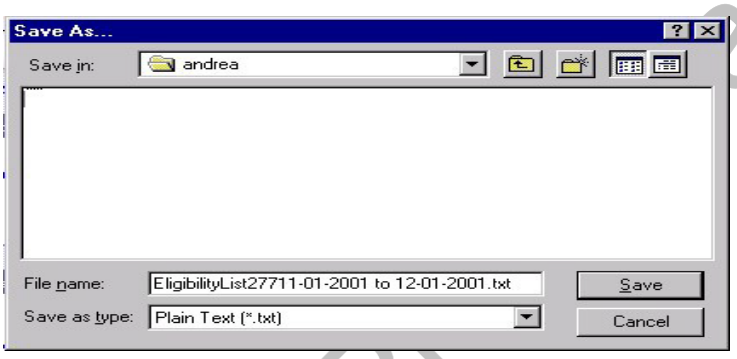
Where do I report other problems or if I have questions?

Please contact your Provider Network Consultant to be assisted in resolving any problems.

To Download Report

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

2. Depending on your browser, you may receive a message box indicating an unknown file type or File Download Dialog Box.
3. Depending on your browser, you may need to click on the **Save File** button, then 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 desired.

- 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.
- Click on the **Save** button.
- The file will be saved in a .txt format to the location selected (step 9).

Additional Functionality

Data Deﬁnition Table

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

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

Data Definition for Member Eligibility List - Netscape

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:

4. Click on the x button at the top of the window.

Clearing Search Form

5. To clear your search criteria at any time, click on the **Clear** button.

6. The search form will be displayed. However, the results report that was displayed will

Importing Downloaded File – Microsoft Access

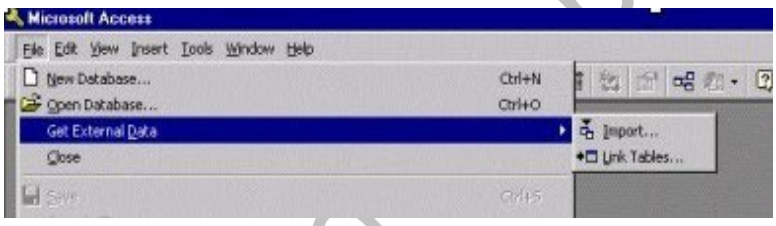
The following includes the steps to import a downloaded file into Microsoft Access. At many steps, pages in parentheses will refer you to the specific section in this document that discusses the page's elements in full detail.

Assumptions:

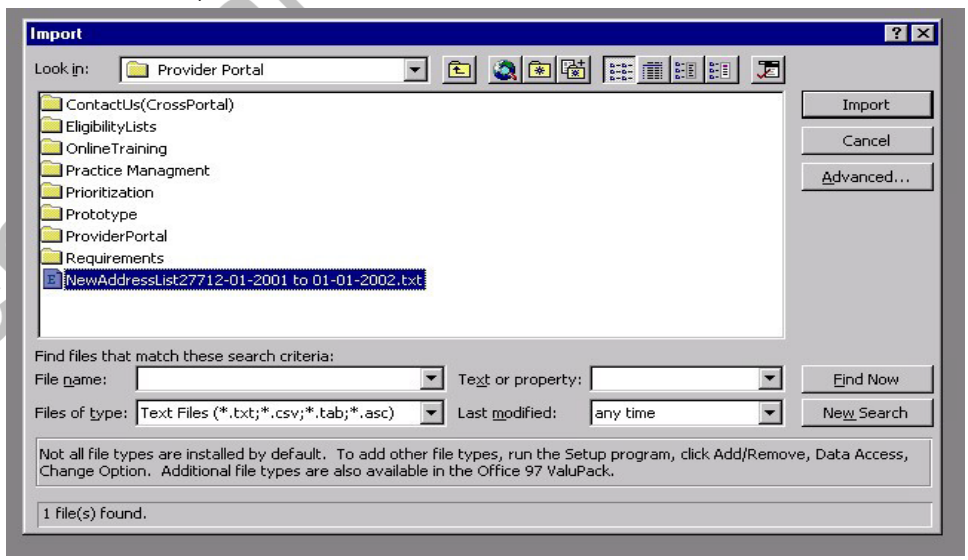
- User has a database open in Microsoft Access.

Instructions:

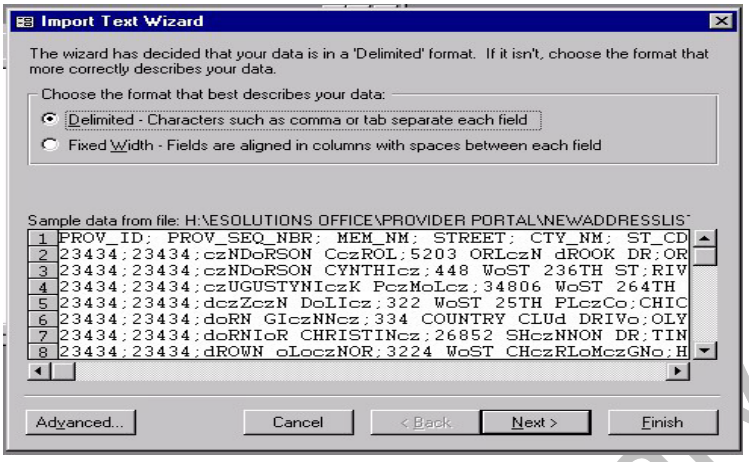
1. Open the database into which you wish to import the data.
2. From the top menu, select **File – Get External Data –Import**.



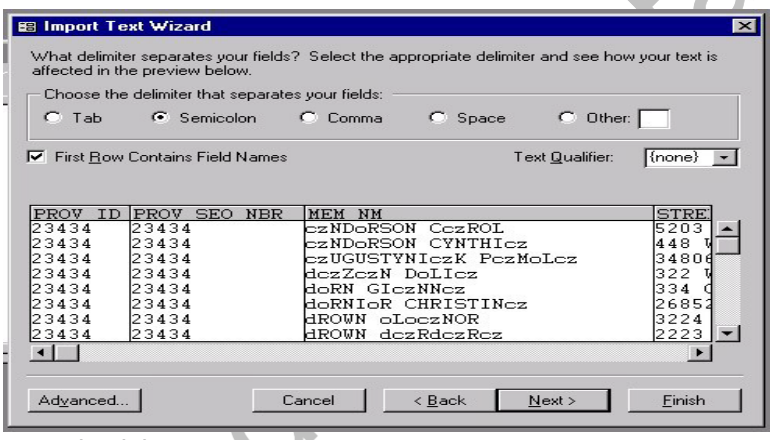
3. Find and select the downloaded file you wish to import (confirm you are looking in the right directory and that you have file type selected as text files).



1. Click the **Import** button.
2. Select the Delimited file type radio button



3. Click the Next button.
4. Select the Semicolon radio button for the delimiter.



5. Check the First Row Contains Field Names check box.
6. Click the **Next** button.
7. Select where you want to import the data. You can:
   - Import to a new table, or
   - Select an existing table
8. Click the **Next** button.
9. Optional step – If desired or necessary, you can specify information about your fields by selecting from the options presented.
10. Click the **Next** button.
11. Select your primary key or allow Access to do it for you by selecting the appropriate radio button.
12. Click the **Next** button.
13. Confirm the table name is where you to import the file.
14. Click the **Finish** button.
15. 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.

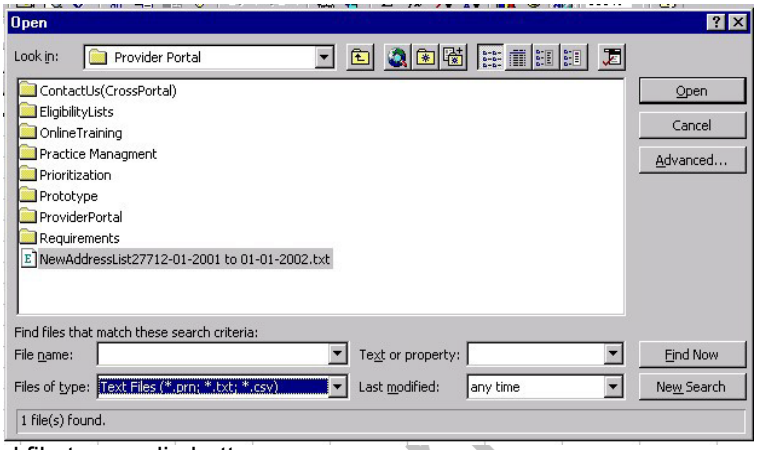
Assumptions:

- User has a database open in Microsoft Excel.

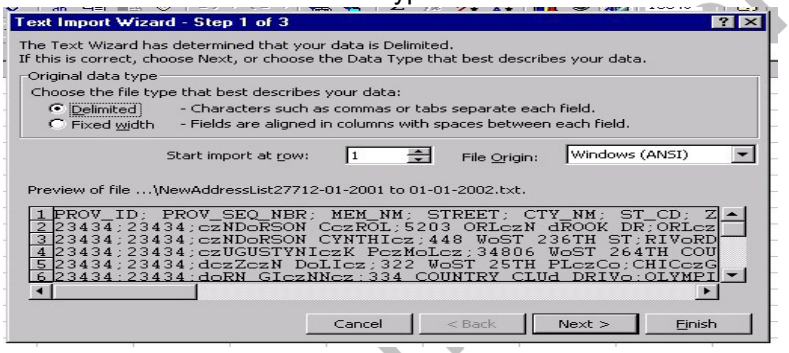
Instructions:

- Open the file into which you wish to import the data.
- From the top menu, select Open.

- 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).

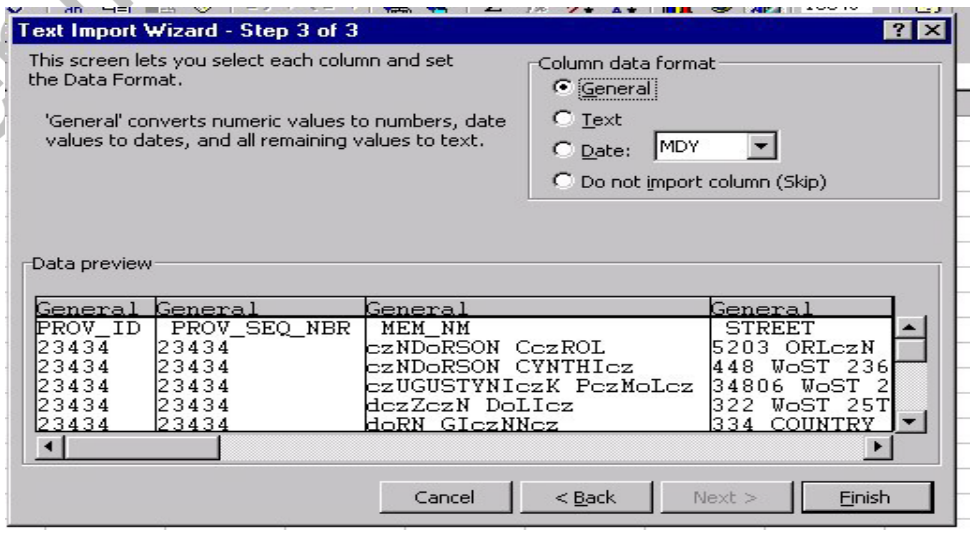


- Click the Open button. Select the Delimited file type radio button.



- Click the **Next** button
- Select the semicolon check box for the delimiter.
- Click the **Next** button.

- 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.**



- Click the Finish button.
- Your data will be imported to your open Excel spreadsheet.

Appeals Out-of-Area Claims

Out-of-area is defined as being outside of the following Illinois Counties: Cook, DuPage, Kane, Kendall, Lake, McHenry and Will. If an IPA refers and approves services for a member who is outside these counties, 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 and send it to the HMO.

The HMO is responsible for processing claims for outpatient, physician and ancillary services, and the physician and hospital claim for a resulting admission, provided services meet the out-of-area Emergency Criteria. All services should have been obtained in an emergency room or a hospital. Required follow-up visits that must occur before members return in-area, due to vacation or business trips, are also covered.

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. Admission to a rehabilitation facility out-of-area from the acute hospital setting is not considered an emergency and is therefore not coverable.

The HMO pays all out of area services that fall under a HMO approved Travel Benefit Period.
The HMO pays all charges for outpatient, physician and ancillary services and the physician and hospital charges for a resulting admission, provided services meet the out-of-the-country Emergency Criteria.

Out-of-Plan Admission Claims

Out-of-plan is defined as being within the following Illinois counties: Cook, DuPage, Kane, Kendall, Lake, McHenry and Will, but not group approved.

The IPA is expected to become involved immediately upon notification of any out-of-plan admission. The IPA will be responsible for authorizing 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.

If the member is stable as determined by the primary care and attending physicians, he/she can be transferred to an in-plan facility or discharged.

If the member declines to be transferred or discharged, the IPA should follow the Termination of Benefits policy (TOB) as outlined in the Utilization Management (UM) section of this manual.

If the IPA is not notified during the admission, the claim should be stamped Non-Group Approved and sent to the HMO. HMO reserves the right to review Non-Group Approved claims and make final determination.

Emergency Room or Emergency Admission Claims

The IPA is financially responsible to pay professional and facility charges for all in-area emergency room services, subject to the IPA's determination that the services meet the definition of an emergency medical condition. HMO reserves the right to make final determination of an emergency medical condition (Refer to DOFR or MSA for financial responsibility).

An admission can occur because of an emergency room visit. The IPA is expected to become involved immediately upon notification of any emergency admission.

Note: More information can be found in the UM section of this manual regarding how to perform UM for these types of admissions.

Organ Transplant Services (Catastrophic Claims)

The HMO considers organ transplants as catastrophic. Group Approved services related to these conditions that are usually the IPA’s responsibility become the HMO’s responsibility. These situations are:

- Organ transplants
- Related pre-surgical laboratory and diagnostic tests performed by the designated transplant facility
- Follow-up within 365 days of the transplant, provided IPA obtained prior approval for organ transplant from the HMO

The HMO will pay the approved provider directly. Each claim must be stamped “Group Approved”. In addition, a note indicating the type of service “Pre-transplant” or “Transplant-related” must be written by the stamp. Use black or blue ink only, do not use a highlighter pen.

The HMO will utilize the posted Appendix D for Transplant Services on MXOTech when referring a member for Transplant related services.

Part D Vaccines Claims Submission Process

Blue Cross Medicare Advantage providers, if providing Part D vaccines in their office, must submit the claim encounter through TransActRX. To enroll, providers or the IPA, if choosing to submit on behalf of their physicians, should go to www.transactrx.com. TransActX FAQ and applicable drugs can be found on the MA HMO Resources section.

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 Medicare Advantage 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 the Contact Management Firm (CMF) 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 the CMF designee, access to all documents, processes, procedures, systems, and other information related to claims processed, paid, or denied by IPA.

IPA shall comply with request for records for audit, review, or monitoring and provide information or access to files within 14 business days to the HMO.

Final Claims Payment Authority

The HMO retains the right and final authority to pay any claims for its members. Any claims paid by the HMO that are the IPA’s responsibility will be deducted from the IPA’s monthly capitation or yearly reconciliation process.

Claims Delegation Performance Requirements

IPA is required to meet at a minimum the following claims processing performance requirements:

- Accurately and timely process at least 95 percent of the total claims according to HMO requirements and in accordance with state and federal laws, rules, and regulations and/or any regulatory or accrediting entity to whom HMO is subject
- Maintain a monthly financial accuracy rate of 99 percent of total dollars paid
- Issue HMO-approved denial letters to members made available to the IPA on the HMO website and comply with Medicare-approved IDN/Plan information notification on mailing envelopes
- Envelope requirements are:
- 40.2 - Font Size Rule
- 42 CFR 422.2264, 423.2264
- All text included on materials, including footnotes, must be printed with a font size equivalent to or larger than Times New Roman twelve (12)-point. The equivalency standard applies to both the height and width of the font.
- 50.16 – Mailing Statements
- 42 CFR 422.2272(b), 423.2272(b)

To help ensure that beneficiaries can quickly and easily identify the contents of a plan sponsor's mailing, all plan sponsors that mail information to prospective or current Medicare beneficiaries must obtain prior approval from the HMO and prominently display one of the following four statements on the front of the envelope or, if no envelope is being sent, the mailing itself. Plan sponsors may meet this requirement using ink stamps or stickers, in lieu of pre-printed statements. Any delegated or sub-contracted entities and downstream entities that conduct mailings on behalf of a plan sponsor must comply with this requirement.

- Advertising pieces – "This is an advertisement"
- Plan information – "Important plan information"
- Health and wellness information – "Health or wellness or prevention information"
- Non-health or non-plan information - "Non-health or non-plan related information"

All mailings should include one of these four mailing statements. If a mailing is not advertising or a health and wellness mailing, but is related to an enrollee's plan, plan sponsors should categorize it as a plan information mailing. However, if the mailing contains non-health or non-plan related information (refer to § 160.2 for examples), a plan sponsor should use the "non- health or non-plan related information" mailing statement. Plan sponsors may not modify these mailing statements and must use them verbatim.
In addition, plan sponsors must help ensure that their plan name or logo is included in every mailing to current and prospective enrollees (either on the front envelope or on the mailing when no envelope accompanies the mailer).

- Issue HMO-approved EOP to providers including HMO-issued appeal language.
- Comply with and meet the rules and requirements for the processing of HMO claims established or implemented by the Centers for Medicare & Medicaid Services (CMS) including, but not limited to, the following:
    - Ninety-five percent of clean claims must be paid within 30 days of receipt by the IPA. Claims that are the IPA's responsibility and forwarded to the IPA by the HMO must be paid within 30 days of receipt by the HMO
    - IPA must pay any CMS mandated interest amounts on all clean claims which are paid later than
      30 days from date of receipt by the IPA or HMO, whichever is applicable
    - All claims received by the IPA must be paid or denied within 60 days of receipt by the IPA or HMO, whichever is applicable
    - Send IDN letters to members within 30 days of receipt of a clean claim
    - Send IDN letters to members within 60 days of receipt of a non-clean claim
    - Maintain NONC documentation for 10 years. Documentation includes copy of the original member or provider request with date and time of receipt and a copy of the NONC letter with the date and time the letter was delivered.
- Meet CMS and state requirements to which HMO is subject for denial and appeals language in all communications made to HMO members, and use only language reviewed and approved by the HMO.

Claims Access, Audits and Oversight

IPA shall allow HMO, the Contact Management Firm (CMF), 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 HMO, or the CMF 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 HMO. This list is not all-inclusive and may be modified by HMO

- IPA's policies, procedures and reports related to claims adjudication
- Samples of claims payments, claims denials and pended claims to test for accuracy and timeliness according to the performance requirements outlined above in Claims Delegation Performance

Requirements. IPA will make all source documentation supporting claims payment, denial or pended claims available to HMO, and/or its designee, upon request.

Compliance with HMO Data Collection Requirements

- Submission of accurate and timely reporting of Encounter Data is required. IPA shall provide to the HMO a semi-monthly Encounter Data file containing all data elements required by the HMO, in a format acceptable to the HMO and in the timeframes as outlined in the Provider Manual and Encounter Data companion guide available on the BCBSIL IPA Access Portal.
    - IPA agrees to submit complete (as verified by HMO analysis) data. Data required to be reported includes, but is not limited to, laboratory data, all Provider services (including capitated services), emergency room, ancillary and any other services that are the payment obligation of the IPA. Data must include Type I and Type II NPI numbers and taxonomy codes as supplied by the Providers. All Encounter data submitted by IPA must include all applicable diagnosis codes.
    - IPA agrees to submit a summary report of claims/encounters submitted and adjudicated for each capitated and employed provider, in a format acceptable to the HMO, indicating how the IPA has tested for completeness of the data. If complete data is not obtained, the IPA must provide an action plan to the HMO on how they will obtain complete claims/encounters for all IPA capitated providers.
- HMO shall review all data submitted by IPA for completeness and accuracy. IPA shall receive a rejection report listing records that are incomplete or fail audit for coding accuracy. IPA must correct and resubmit records to HMO within 10 days from notification of the rejection.

- With each Encounter Data submission, IPA agrees that it certifies that Encounter Data has been evaluated for accuracy, completeness, and timeliness prior to submission. In the event HMO becomes aware that Encounter Data is not accurate, complete, and/or timely, HMO may elect to impose penalties as outlined in this provision.

- The HMO may perform a series of validation edits to evaluate whether or not the Encounter Data submitted meets HMO required submission standards. IPA shall be notified of any errors resulting in the rejection of an Encounter Data record. IPA shall correct and resubmit rejected records according to HMO established procedures no later than ten (10) business days from HMO notification to IPA of such error.

- Additionally, the IPA shall provide to the HMO a quarterly detailed report of claims/encounters submitted and adjudicated, regardless of reimbursement methodology, in a format acceptable to the HMO. IPA shall also provide such a report upon HMO request. The report must include an explanation of how the IPA has tested for completeness, accuracy and timeliness of the data. If the IPA determines the data is not complete, accurate or timely the IPA must submit an action plan outlining how the IPA will obtain and submit complete, accurate and timely claims/encounter data.

Claims Reporting Requirements

Below is a list of reporting requirements IPA is required to submit to HMO. This is not an all-inclusive list and is subject to modification by HMO.

Claims Reporting Requirements

Mandatory Reporting	Frequency	Description
Accumulator Data Reporting	Weekly	Member level out-of-pocket expense applied to claims and encounters processed by IPA
Encounter Data	Monthly	All claims and encounters adjudicated by IPA including fully favorable, partially favorable, and unfavorable payment determinations as defined in section Claims – Organization Determination/Reconsiderations Reporting
Claims Payment Turnaround Time Reporting	Monthly	HMO will generate report using monthly data submitted by IPA

Claims – Organization Determination/Reconsiderations Summary	Monthly	Count of claims meeting Fully Favorable, Partially Favorable and Unfavorable payment decisions as defined in section Claims – Organization Determination/Reconsiderations Reporting
Claims – Organization Determination/Reconsiderations Detail	As requested by HMO	Copy of original claim(s)
Claims – Non-Contracted Provider Appeals	Per Occurrence	Copy of Appeal, waiver, and outcome to be faxed to the Govt. Program Network Department at 312.729.7175
Serious Reportable Adverse Events or Hospital Acquired Conditions – Summary	Annually	See section on Serious Reportable Adverse Events or Hospital Acquired Conditions Reporting
Serious Reportable Adverse Events or Hospital Acquired Conditions – Detail	As requested by HMO	Copy of original claim(s)
~~Claims and Encounter Summary Report~~	~~Quarterly~~	~~Summary report of claims/encounters submitted and adjudicated for each capitated and employed provider~~
Copy of Provider EOP	Annually	Provider Explanation of Payment including HMO required appeals language
Copy of Record Retention Policy and Procedure	Annually	
Copy of Disaster Recovery Plan	Annually	

Frequency	**Submission to HMO by:**
Weekly	On Monday end of business
Monthly	Within 5 days following the end of the month
Quarterly	Within 30 days following the end of the quarter
Annually	Within 30 days following the end of the calendar year
As requested by HMO	Within 5 days from the date of HMO request

Claims – Accumulator Reporting

The IPA is responsible for accurately identifying members who have reached the HMO out-of-pocket maximum limits. The IPA may not apply member copayments and/or coinsurance to any claims processed for members who have reached the HMO plan benefit out-of-pocket maximum.

IPA is required to help ensure that the member is refunded all appropriate overcharges related to IPA responsible claims when the out-of-pocket maximum for the member has been met. The IPA will help ensure that the member receives the refund within 15 days of notification that the member has met the out-of-pocket maximum. Failure to help ensure that the member refund has been issued may result in HMO reimbursing the member and deducting amounts from IPA capitation.

- IPA is required to submit a weekly Claim Accumulator Report to HMO in the HMO required format
- HMO will send IPA a daily Claim Accumulator Report which will include member level out-of-pocket expense representing the total out-of-pocket expense to date for all claims including HMO, IPA and pharmacy (if applicable) services.

Claims – Organization Determination/Reconsiderations Reporting

IPA is required to report: organization determinations and reconsiderations, as described in this section, regardless of whether the request was filed by the member, the member's representative, a physician or a non-contracted provider who signed a Waiver of Liability.

An **organization determination** is IPA's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, prior authorization requests, and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.

A **reconsideration** is the IPA's review of an adverse or partially favorable organization determination.

A submitted claim is a request for organization determination. All claims are reportable organization determinations and must be reported under one of the following categories:

- A **Fully Favorable** decision means an item or service was covered and paid in whole.
- A **Partially Favorable** decision means an item or service was partially covered or paid (e.g., If a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable; if a pre-service request for 10 therapy services was processed, but only five were authorized, this would be considered partially favorable).
- An **Unfavorable** decision means an item or service was denied in whole.

Reporting Exclusions

Do not report:

- Dismissals or withdrawals.
- Duplicate payment requests concerning the same service or item.
- Payment requests returned to a provider/supplier in which a substantive decision (Fully Favorable, Partially Favorable or Adverse) has not been made due to error – e.g., payment requests or forms are incomplete, invalid or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).

Claims – Organization Determination/Reconsiderations – Summary Report

Data Elements for Organization Determinations/Reconsiderations

Number of Organization Determinations – Fully Favorable
Number of Organization Determinations – Partially Favorable
Number of Organization Determinations – Adverse
Number of Reconsiderations – Fully Favorable
Number of Reconsiderations – Partially Favorable
Number of Reconsiderations – Adverse

Claims – Provider Claim Appeals

IPA is required to use the standard Explanation of Payment (EOP) language. A sample of the EOP language can be found under the Blue Cross Medicare Advantage (MA) HMO Resources.

Contracted Provider Appeal Process

IPA is to follow their standard appeal process.

Non-contract Provider Appeals Process

(Rev. 105, Issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)

A non-contract provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal. See Appendix 7.

Physicians and suppliers who have executed a waiver of beneficiary liability are not required to complete the CMS-1696, Appointment of Representative, form. In this case, the physician or supplier is not representing the beneficiary, and thus does not need a written appointment of representation. Furthermore, because the enrollee no longer has an appealable interest under Subpart M of Part 422, Medicare health plan notices/correspondence

regarding the non-contract provider's appeal should be delivered to the non-contract provider but not the enrollee.

When a non-contract provider files a request for reconsideration of a denied claim but the non-contract provider does not submit the waiver of liability or other documentation as per section 40.2.3 upon the Medicare health plan's request, the Medicare health plan must make, and document, its reasonable efforts to secure the necessary waiver of liability form and other documentation. The Medicare health plan should not undertake a review until or unless such form/documentation is obtained. The time frame for acting on a reconsideration request commences when the properly executed waiver of liability form and other documentation is received. However, if the Medicare health plan does not receive the form/documentation by the conclusion of the appeal time frame, the Medicare health plan should forward the case to the independent review entity with a request for dismissal. The Medicare health plan must comply with the IRE's Reconsideration Process Manual section on reconsiderations that fail to meet provider-as-party requirements.

IPA will need to determine if the requesting Provider is a Blue Cross Medicare Advantage HMO contracted Provider. IPA will use the Blue Cross Medicare Advantage Provider Finder® to determine requesting Provider's participation in the network.

If the provider is a non-contracted, IPA must obtain the CMS approved waiver of liability (copy available on website), which states that the non-contract Provider will not bill the enrollee regardless of the outcome of the appeal.

IPA is required to report these appeals received by a non-contracted Provider.

Reporting should be sent to the IPA's Government Program Network Management department and the HMO's ODAG department.

Serious Reportable Adverse Events (SRAEs) or Hospital Acquired Condition (HAC) Reporting

IPA is required to report SRAEs or HACs, as described in this section. CMS Part C reporting requirements change annually and may change during a calendar year. The information below represents the SRAE and HAC reporting requirements as of Oct. 1, 2012. HMO will provide IPA with changes to SRAE or HAC reporting requirements within 60 days from the date of publication.

- All claims for this measure are based on incurred date for the calendar year.
- If an SRAE is reported on a claim and there in an" N" (N =" No") in the Present on Admission (POA) field, this is considered a confirmation that the SRAE was acquired during the hospital stay.
- All SRAEs and HACs are mutually exclusive. If a claim has a code for an SRAE and anHAC, the IPA should report both.
- Adverse health conditions present upon admission should be excluded from this measure. For surgical site infection HACs, the diagnosis code and procedure may be on the same claim, or on different claims.
- For those instances where a member incurs multiple SRAEs or HACs associated with multiple procedures, report the SRAEs or HACs associated with all those procedures.

Codes to Identify Serious Reportable Adverse Events

The POA indicator must be "N" for "No" for a condition to be counted as a serious reportable adverse event or as an HAC.

Event Description	CPT	ICD-9-CM Procedure	ICD-9-CM Diagnosis	MSDRG
Surgery on Wrong Body	n/a	n/a	E876.5 (not specific to this event)	n/a
Surgery on Wrong Patient	n/a	n/a	E876.5 (not specific to this event)	n/a

Wrong Surgical Procedures on a Patient	n/a	n/a	E876.5 (not specific to this event)	n/a
Surgery with Post-Operative Death in Normal Healthy Patient			ASA category 1 (a normal healthy patient)	

Codes for Identifying Hospital Acquired Conditions (HACs)

Selected HAC	**CC/MCC (ICD-9-CM Codes)**
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Stage III & IV Pressure Ulcers	The diagnosis codes for stage III and IV Pressure Ulcers are as follows: • Pressure ulcer, stage III • Pressure ulcer, stage IV
Falls and Trauma: • Fractures • Dislocations • Intracranial Injuries • Crushing Injuries • Burns • Other & Unspecified Effects of External Causes	Codes within these ranges on the CC/MCC list: 800-829 (Fractures) 830-839 (Dislocations) 850-854 (Intracranial Injuries) 925-929 (Crushing Injuries) 940-949 (Burns) 991-994 (Other & Unspecified Effects of External Causes)
Vascular Catheter-Associated Infection	999.31 (CC)
Catheter-Associated UTI	996.64
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC)250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infection-Mediastinitis after Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.83, 81.83, 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	*Principal Diagnosis* – 278.01 998.59 (CC) and one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

Serious Reportable Adverse Events (SRAEs) – Summary Report

Data Elements

Measure (includes SRAEs and HACs)	Comments
Number of total surgeries	Must have occurred in acute hospital.
Number of surgeries on wrong body part	Must have occurred in acute hospital.
Number of surgeries on wrong patient	Must have occurred in acute hospital.
Number of wrong surgical procedures on a patient	Must have occurred in acute hospital.
Number of surgeries with post-operative death in normal health patient	Must have occurred in acute hospital.
Number of surgeries with foreign object left in patient after surgery	Must have occurred in acute hospital.
Number of Air Embolism events	Must have occurred in acute hospital.
Number of Blood Incompatibility events	Must have occurred in acute hospital.
Number of Stage III & IV Pressure Ulcers	Must have occurred in acute hospital.
Number of fractures	Must have occurred in acute hospital.
Number of dislocations	Must have occurred in acute hospital.
Number of intracranial injuries	Must have occurred in acute hospital.
Number of crushing injuries	Must have occurred in acute hospital.
Number of burns	Must have occurred in acute hospital.
Number of Vascular Catheter-Associated Infections	Must have occurred in acute hospital and be diagnosed during hospital stay.
Number of Catheter-Associated UTIs	Must have occurred in acute hospital and be diagnosed during hospital stay.
Number of Manifestations of Poor Glycemic Control	Must have occurred in acute hospital and be diagnosed during hospital stay.
Number of SSI (Mediastinitis) after CABG	30-day inclusion period following discharge. Data for the CC/MCC code to be found from hospital claims only.
Number of SSI after certain Orthopedic Procedures	365-day inclusion period following discharge. Data for the CC/MCC code to be found from hospital claims only.
Number of SSI following Bariatric Surgery for Obesity	30-day inclusion period following discharge. Data for the CC/MCC code to be found from hospital claims only.
Number of DVT and pulmonary embolism following certain orthopedic procedures	Must have occurred in acute hospital and be diagnosed during hospital stay.

Introduction

If a member has coverage with another plan that is primary to Medicare, the claim should be submitted for payment to that plan first. The amount payable by Blue Cross Medicare Advantage HMO will be governed by the amount paid by the primary plan and Medicare Secondary Payer law and policies.

Definitions

- “This Plan” means Blue Cross Medicare Advantage HMO. If “This Plan” is the primary carrier for a member, then “This Plan” will provide its services and benefits in full regardless of the benefits available to the member from any “Other Plan.”
- "Other Plan" means any Plan providing benefits or services for inpatient hospital or outpatient medical care. If “This Plan” is Secondary Carrier for a member, then “This Plan” will provide its benefits only after the primary carrier has paid for covered benefits. This is if all pertinent rules of the Medicare HMO were followed (e.g., services were performed or referred by the Primary Care Physician). The Medicare HMO will need a copy of the primary carrier’s explanation of benefits (EOB) to process all claims.

- "Primary Carrier" means a Plan, which according to the "Order of Benefit Determination" provisions of Part B below, has primary responsibility of benefits.
- "Secondary Carrier" means a Plan which, according to the "Order of Benefit Determination" provisions of Part B below, has secondary responsibility for the provision of benefits after the primary carrier determines its benefits.

Order of Benefit Determination

These rules apply for employer or union group health plan coverage:

- If the enrollee has retiree coverage, Medicare pays first.
- If the enrollee's group health plan coverage is based on their or a family member's current employment, who pays first depends on their age, the size of the employer and whether they have Medicare based on age, disability or End Stage Renal Disease (ESRD):
    - If the enrollee is under 65 and disabled and the enrollee or their family member is still working, the enrollee's plan pays first if the employer has 100 or more employees, or at least one employer in a multiple employer plan has more than 100 employees.
    - If the enrollee is over 65 and the enrollee or their spouse is still working, the plan pays first if the employer has 20 or more employees, or at least one employer in a multiple employer plan has more than 20 employees.
- If the has Medicare because of ESRD, the enrollee's group health plan will pay first for the first 30 months after they become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans and/or Medigap have paid.

Medicare Secondary Payer Demand Letter

The Medicare Secondary Payer Statute is a provision of the Social Security Act. It refers to those instances in which Medicare does not have the primary responsibility for paying the medical expenses of a Medicare beneficiary because the beneficiary is entitled to other coverage that should pay primary health benefits.

There are times when the Centers for Medicare & Medicaid Services (CMS) will send a Medicare Demand Letter if Medicare has paid claim as Medicare primary in error. This letter contains a summary data sheet, a payment record summary and the claims that are involved in the reimbursement to Medicare. This Demand Letter requires that the HMO reimburse Medicare in full for their expenses for the health care services that it paid as primary in error.

The HMO reviews the Medicare Demand Letter and verifies the eligibility, claim information, and identifies the appropriate IPA. The HMO will send a Medicare Secondary Payment Request Letter to the IPA including Summary Claims Listing. The IPA will have five business days to respond to the request.

The IPA should complete the Summary Claims Listing first indicating if the claim was group approved or not group approved. If the IPA has not previously paid a group approved claim, no payment should be made based upon this review.

If the claim was group approved, the IPA should indicate the amount paid, the check number, the date paid and payer information on the form. If a partial payment was made, the IPA should indicate the reason (e.g., was paid due to contract agreement with the provider or it was paid as a secondary payer). If no payment was made, this should be documented.

If the IPA paid the claim as a primary payer (through capitation, contract agreement or payment in full), the HMO will not need to reimburse Medicare.

If the IPA paid the claim as a secondary payer or if the IPA has approved the claim but has not yet paid as the secondary payer, Medicare is reimbursed at the requested level. This amount will be deducted from the IPA's next capitation check. A Summary Notification Letter will be sent to the IPA confirming the capitation deduction.

Worker's Compensation

The Illinois Workers' Compensation Act provides that an insured employee has the right to obtain medical care for treatment of a work-related injury. If the employee chooses to use the services of the chosen IPA, the charges or equivalents for these services should be recouped through the employer's Workers' Compensation carrier. The IPA must provide the services under the terms of the Medical Service Agreement (MSA). The IPA must not bill the member. A member can be questioned to determine whether the injury a) occurred at work or b) during their work duties

Regular follow up by the IPA, via certified mail, is recommended to ensure reimbursement. Liens should not be issued for Workers' Compensation claims.

Right to Recovery

The IPA has the right to recovery after they have rendered services for an injury and the member attempts to collect payments by an action at law, settlement or otherwise. Benefits provided must be for covered services under the Subscriber Certificate. The member may not be denied service, nor can any IPA Provider bill the member for services managed or authorized by the IPA that may be related to a third-party.

In the event of accidental injury outside of work or when some party other than the employer or co-employees are responsible for the injury, there is a right to recovery of these monies from the responsible party (i.e., insurance carrier). A lien for medical or hospital treatment can be perfected against the insured, the responsible party and the responsible party's insurance carrier. This must be perfected by the medical provider and not the HMO. No lien can be filed unless there is a claim or litigation pursued by the member. The member should not be pursued for any amount other than the applicable copayments, coinsurance and/or deductible.

Capitation Payment

De[?]inition

Under the HMO agreement outlined in the Medical Service Agreement (MSA), physicians will receive a monthly capitation (cap) payment for every member that selects them as their Primary Care Physician (PCP). Cap is paid regardless of the number of times the member visits their PCP. Having an eligible member select a PCP within the IPA guarantees a monthly cap payment to the IPA. Capitation will continue to be paid for a member who is enrolled in an HMO approved Travel Benefit time period.

The capitation payment, which is made to the IPA by the 10th of each month, is a "net" capitation payment. The specific steps for calculating the net capitation payment are detailed below.

Calculation of Capitation Payment

BlueCap (current capitation system) calculates current and retroactive capitation amounts paid to the IPAs. The cap payment amount is derived from the Capitation Payment Exhibit listed in the MSA.

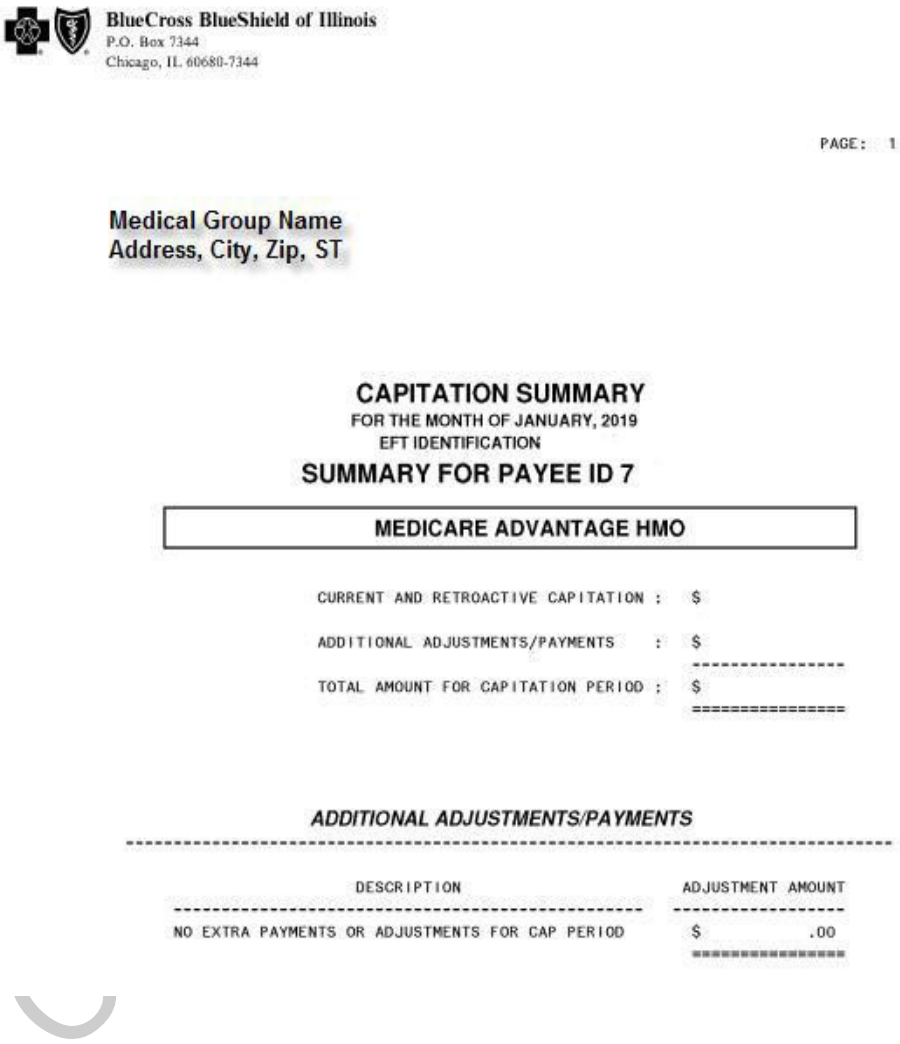
Current and retroactive calculations are listed in the Capitation Summary report. The Capitation Summary is available monthly to the IPA along with their cap check or emailed to the IPA if the IPA has an Electronic Funds Transfer (EFT) agreement. If the IPA has any questions about the calculation of its monthly capitation check, this Summary should be consulted first.

The Capitation Payment Summary Key

Use the following key to understand the HMO Capitation Payment Summary.

- **Month:** Month for which capitation is being paid
- **IPA Number and IPA NPI Number:** Identification number and the National Provider Identifier (NPI) of the IPA to whom capitation is being paid
- **Current and Retroactive Capitation:** Dollar amount of current and retroactive calculated capitation
- **Additional Adjustments/Payments:** Dollar amount (positive or negative) of manual adjustments to the month's capitation
- **Description:** A brief description of the Additional Adjustment/Payment

Sample HMO Capitation Payment Summary



BlueCross BlueShield of Illinois
P.O. Box 7344
Chicago, IL 60680-7344

PAGE: 1

Medical Group Name
Address, City, Zip, ST

CAPITATION SUMMARY
FOR THE MONTH OF JANUARY, 2019
EFT IDENTIFICATION
SUMMARY FOR PAYEE ID 7

MEDICARE ADVANTAGE HMO

CURRENT AND RETROACTIVE CAPITATION :	$	
ADDITIONAL ADJUSTMENTS/PAYMENTS :	$	
TOTAL AMOUNT FOR CAPITATION PERIOD :	$	

ADDITIONAL ADJUSTMENTS/PAYMENTS

DESCRIPTION	ADJUSTMENT AMOUNT
NO EXTRA PAYMENTS OR ADJUSTMENTS FOR CAP PERIOD	$ .00

Comparison of Capitation Payment Summary with the Eligibility List Summary

The Eligibility List Summary is a computer count of all active members as of the date the Eligibility List is generated.

To reconcile the current month's capitation, check the following:

- Download the Capitation Reconciliation report from the Blue Access for Providers℠ for the month in question. Sum the totals of the PCP_RETRO_CAP_AMT and PCP_CURR_CAP_AMT. Add the results of these two fields. The total should be equal to the Current and Retroactive Capitation total from the Capitation Summary.

The following rules apply regarding retroactive changes:

MA	Member Add:	Limited to 24 member months
MC	Member Cancel:	Limited to 3 member months
TI	Transfer In:	Limited to 24 member months
TO	Transfer Out:	Limited to 24 member months
RI	Reinstate:	Limited to 24 member months
NC	Name Change:	Limited to 24 member months
BC	Date of Birth Change:	Limited to 24 member months
CC	Cancel Date Change:	Limited to 24 member months
EC	Effective Date Change:	Limited to 24 member months
GC	Gender Change:	Limited to 24 member months
MM	Medicare Maintenance:	Limited to 24 member months
HC	History Change:	Limited to 24 member months
RA	Rate Adjustment:	Limited to 24 member months

Organ Transplant Services (Catastrophic) Claims

The HMO considers organ transplants as catastrophic. Group Approved services related to these conditions that are usually the IPA's responsibility become the HMO's responsibility. These situations are:

- Organ transplants
- Related pre-surgical laboratory and diagnostic tests performed by the designated transplant facility
- Follow-up within 365 days of the transplant, provided IPA obtained prior approval for organ transplant from the HMO

The HMO will pay the approved provider directly. Each claim must be stamped "Group Approved". In addition, a note indicating the type of service "Pre-transplant" or "Transplant-related" must be written by the stamp. Use black or blue ink only, do not use a highlighter pen.

Quality Improvement Program Overview

The HMO Quality Improvement Program (QIP) is intended to reward the IPA for maintaining high quality and patient satisfaction standards in the delivery of covered services as outlined in the MSA.

The HMO shall pay the IPA for participating in QI activities with payment based upon performance as specified below. QIP Clinical Measure performance thresholds will be established by the HMO on an annual basis. (Refer to your current year QIP).

Part D Prescription Drug Fund

The Prescription Drug Fund is determined annually and subject to the execution of the MSA. It is based on the relative performance of the IPA in judiciously managing the use of the prescription drug benefit.

The Medicare pharmacy team sends monthly reporting via e-mail to clinical contacts. The reports aim to improve metrics for Part D Stars measures including Statin Use in Persons with Diabetes, and Medication Adherence for Diabetes Medications, Hypertension Medications and Statins. Reporting includes opportunities for gap closure for Statin Use in Persons with Diabetes (SUPD)and a full medication adherence report.

Copayments

Copayments are the payment for Covered Services that the Member may be responsible for paying each time a medical service is accessed as outlined in the Member's Evidence of Coverage.

Types of out-of-pocket costs your member may pay for covered services, which can be referenced by reviewing the member's annual Evidence of Coverage (EOC). The EOC is located and may be accessed through the plan documents on the BCBSIL.com website under Medicare Tools and Resources > Forms and Documents. See below for direct link. Please reference the member's ID card for the specific plan type.

https://www.bcbsil.com/medicare/tools-resources/forms-documents/mapd-plan-documents

Coinsurance

Coinsurance is the percentage a member may pay of the total cost of certain medical services based on their plan type. Co-Insurance percentages may be referenced and is outlined in the Member's Evidence of Coverage (EOC). The EOC is located and may be accessed through the plan documents on the BCBSIL.com website under Medicare Tools and Resources > Forms and Documents. See below for direct link. Please reference the member's ID card for the specific plan type.

https://www.bcbsil.com/medicare/tools-resources/forms-documents/mapd-plan-documents

QMB

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments, or coinsurance. Members are asked to show proof of Medicaid or QMB eligibility at the time of a provider visit. QMB status may be identified in the monthly eligibility files. Please reference the MA HMO Membership section for identification instructions of a QMB Member.

Medical Records

For the purposes of Centers for Medicare & Medicaid Services (CMS) and for the purposes set forth below, IPA providers are required under the MSA to provide medical records requested by the HMO. Purposes for which medical records from providers are used by HMO include, but are not limited to:

- Advance determinations of coverage
- Plan coverage
- Medical necessity
- Proper billing
- Quality reporting
- Fraud and abuse investigations
- Plan initiated internal risk adjustment validation

Electronic Health Record to Accommodate MACRA

If the Practice is a group comprised of multiple Health Care Providers, then at least seventy-five percent (75%) of such Health Care Providers must utilize Certified Electronic Health Record Technology as defined in 42 C.F.R. § 414.1305 as amended from time to time, to document and communicate clinical care. The practice will make available to the Plan any information or documentation requested by the Plan to confirm compliance with this requirement.

This requirement will only apply if your Practice is participating in the MACRA through the Other Payer Advanced APM pathway.

Initial Health Risk Assessment

CMS requires that a good faith effort is made to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment and follows up on unsuccessful attempts to contact an enrollee.

Annual Health Assessment

The Blue Medicare Advantage HMO Annual Health Assessment (AHA) serves as a platform to help identify essential clinical and care management needs of members and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the member's past medical history, social history, family history, physical exam (including BMI), preventive screenings and chronic disease monitoring. These assessments can occur in the provider's office or member's home. The Annual Health Assessments are part of the Quality Program. The Annual Health Assessment Form is available on our website in the Blue Medicare Advantage (MA) HMO Resources section

Process for Submitting AHA

1. The IPA Provider conducts a face-to-face annual visit with the member and completes the Annual Health Assessment Form according to the instructions provided.
2. The IPA Provider completes the encounter claim documenting the appropriate diagnosis codes and submits via normal claims submission. The provider shall document on the encounter claim the appropriate HCPCS codes for well visits for medical billing purposes:

   G0402 – Initial Preventive Physical Examination
   Code is limited to new beneficiary during the first 12 months of Medicare Enrollment.
   G0438 – Annual Wellness Visit (AWV), Initial
   The initial AWV, G0438, is performed on patients that have been enrolled with Medicare for more than one year, including new or established patients.
   G0439 – Annual Wellness Visit (AWV), Subsequent
   The subsequent AWV occurs one year after the patient initial visit.
3. The provider ensures all required fields are completed on the AHA form within their EMR system. The form shall be kept on file and should be available upon request from BCBSIL. Please send any questions about this form to: RiskAdjustment@bcbsil.com.
4. The IPA provider conducts a face-to-face annual visit with the member and completes the Annual Health Assessment Form according to the instructions provided.
5. The IPA provider completes the encounter claim documenting the appropriate diagnosis codes and submits via normal claims submission to the IPA.
6. The IPA provider shall document on the encounter claim the appropriate HCPCS codes for well visits for medical billing purposes.

G0402 – Initial Preventive Physical Examination
Code is limited to new beneficiary during the first 12 months of Medicare Enrollment.
G0438 – Annual Wellness Visit (AWV), Initial
The initial AWV, G0438, is performed on patients that have been enrolled with Medicare for more than one year, including new or established patients.
G0439 – Annual Wellness Visit (AWV), Subsequent The subsequent AWV occurs one year after the patient initial visit.

AHA Telehealth Visits

AHAs can be done via telehealth for G0438 and G0439 and are advising the provider to bill with POS 11 and Modifier 95. G0402 - Initial Preventive Physical Examination is NOT approved for Telehealth by CMS.
If the Provider is billing G0438 or G0439, it will be calculated for their AHA performance since they are the same codes we use today. All telehealth services must have both audio and visual to meet the 'face to face' requirement for risk adjustment purposes. Telephone or audio only encounters do not count for risk adjustment purposes.

Telehealth must be billed: POS 11 and modifier 95 ***or*** POS 02 no modifier. The Member will not be responsible for copays, coinsurance, or deductibles as it will be considered part of the preventive visit.

New Annual Wellness Visit Resources for Medicare Providers

Annual Wellness Visit Guide: includes a wellness visit checklist
Annual Wellness Visit Form: new form includes sections for member's medical history, risk factors, conditions, treatment options, coordination of care, and advance care planning.

More information posted on BCBSIL Website under News & Updates:
https://www.bcbsil.com/provider/education/2020/2020_05_01.html

Medicare Bene[?]iciaries receiving these services must have their copayment and/or coinsurance waived.

The codes, G0402, G0438 and G0439 are preventative services and members receiving these services do not pay a copayment for their visit. If the provider bills an Evaluation & Management (E&M) code in conjunction with the "G" code the CMS guidelines for billing with a modifier should be utilized. Evaluation & Management (E & M) code (example: 99245) with the "G" code, your claim processing system must waive the copayment, because the "G" code is considered a preventative service.

Both the E & M code and the "G" code should be submitted to Blue Medicare Advantage as part of the monthly delegated claims encounter submission.

Marketing

IPA providers may not develop and use any materials that market Blue Medicare Advantage HMO without prior approval of Blue Medicare Advantage HMO in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are approved prior to use by CMS or are submitted to CMS and not disapproved within 45 days.

Sanctions under Federal Health Programs and State Law

IPA and their participating providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement with Medicaid, Medicare or other federal health care programs are employed or subcontracted by the participating provider.

IPAs and their participating providers must disclose to Blue Medicare Advantage HMO whether the participating provider or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws, the rules or regulations of the State of Illinois, the federal government, or any public insurer. Participating providers must notify Blue Medicare Advantage HMO immediately if any such sanction is imposed on a participating provider, a staff member or subcontractor.

Quality Improvement Program

Quality improvement is an essential element in the delivery of care and services by Blue Cross Medicare Advantage (HMO/PPO). To define and assist in monitoring quality improvement, the Blue Cross Medicare Advantage (HMO/PPO) Quality Improvement Program focuses on measurement of clinical care and service delivered by physician, professional provider, facility, or ancillary providers against established goals. Key components of the program described below include the Chronic Care Improvement Program (CCIP), Quality Improvement Projects (QIPs) and performance monitoring (HEDIS, CAHPS, HOS). Formal evaluation of the program occurs annually to assess the impact and effectiveness of the program.

Chronic Care Improvement Program (CCIP)

A set of interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions and include patient identification and monitoring.

Other programmatic elements may include the use of evidence- based practice guidelines, collaborative practice models involving physicians as well as support-services providers, and patient self-management techniques.

Quality Improvement Project (QIP)

An organization's initiative that focuses on specified clinical and non-clinical areas.

Healthcare Effectiveness Data and Information Set (HEDIS®)

A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

A patient's perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., MAOs, PDPs, PFFS) are asked for their perspectives of care that allow meaningful and objective comparisons between providers on domains that are important to consumers; create incentives for providers to improve their quality of care through public reporting of survey results; and enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment.

Health Outcomes Survey (HOS)

This survey is the first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of members from each Medicare Advantage organization health plan is surveyed. Two years later these same members are surveyed again to evaluate changes in health.

Quality of Care Issues

The Quality Improvement Program includes aggregation and analysis of trend for quality-of-care issues. A quality-of-care complaint may be filed through the Medicare health plan's grievance process and/or the Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO).. A BFCC-QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare managed health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

The QIO is comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers.

CMS Star Ratings

The Centers for Medicare and Medicaid Services (CMS) posts quality ratings of Medicare Advantage plans to provide Medicare beneficiaries with additional information about the various Medicare Advantage plans offered in their area. CMS rates Medicare Advantage plans on a scale of one to five star and defines the star ratings in the following manner:

5 Stars = Excellent performance
4 Stars = Above average performance
3 Stars = Average performance
2Stars = Below average performance
1 Star = Poor performance

The quality scores for Medicare Advantage plans are based on performance measures from the following sources:

- Healthcare Effective Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®))
- Health Outcomes Survey (HOS)
- Administrative data

- Prescription Drug Event (Part D)
- Improvement of Plan's Performance

CMS groups the quality measures into nine domains:

- Staying healthy: Screenings, Tests, and Vaccines
- Managing Chronic(long-term) Conditions
- Member Experience with Health Plan or Drug Plan
- Member Complaints and Changes in the Health Plan's Performance or Drug Plan's Performance
- Health Plan or Drug Plan Customer Service
- Drug Safety and Accuracy of Drug Pricing

Part C measures are grouped to calculate a Part C rating. Part D measures are grouped to calculate a Part D rating. For MA-PDs, all unique Part C and Part D measures are grouped to create an overall rating.

Cooperation

Participating physician, professional provider, facility or ancillary providers must comply and cooperate with all Blue Cross Medicare Advantage (HMO/PPO) Medical Management policies and procedures and in the Blue Cross Medicare Advantage (HMO/PPO) Quality Assurance and Performance Improvement Programs. In addition, participating physician, professional provider, facility or ancillary providers must cooperate with the independent quality review and improvement organization, [Quality Improvement Organization (QIO)], approved by CMS in its review of quality of care and investigation of quality complaints on behalf of the Medicare program. Livanta is the QIO for Blue Cross Medicare Advantage (HMO/PPO).

Appeal

Any of the procedures that deal with the review of adverse determinations on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. The procedures may include reconsiderations by Blue Cross Medicare Advantage HMO, an independent review entity (IRE), hearings before an Administrative Law Judge (ALJ), review by the Medicare Appeals Council and federal judicial review.

Annual Health Assessment

The Blue Cross Medicare Advantage HMO/POS Annual Health Assessment (AHA) serves as a platform to identify essential clinical and care management needs and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the member's past medical history, social history, family history, physical exam (including BMI), preventive screenings and chronic disease monitoring. These assessments can occur in the provider's office or member's home to remove barriers to completion. The Annual Health Assessments are part of the Quality Program. The Annual Health Assessment Form is available on the provider portal.

Basic Benefits

All health care services covered under the Medicare Part A and Part B Programs, except hospice services and additional benefits. All members of Blue Cross Medicare Advantage HMO are eligible to receive all covered basic benefits.

Center for Health Dispute Resolution (CHDR)

An independent Centers for Medicare & Medicaid Services (CMS) contractor that reviews appeal by members of Medicare managed care plans, including Blue Cross Medicare Advantage HMO.

Centers for Medicare & Medicaid Services (CMS)

CMS is the federal agency responsible for administering Medicare.

Covered Services
Those benefits, services or supplies that are:

- Covered under the HMO Medicare Plan and approved for a member by an IPA Primary Care Physician
- Emergency services and urgently needed services that may be provided by non-contracted providers
- Renal dialysis services provided while the member is temporarily outside the service area.
- Basic and supplemental benefits

Detailed Explanation of Non-Coverage (DENC)
The CMS and HMO approved form to be completed and issued upon notice from the Quality Improvement Organization QIO that a member has appealed termination of services for skilled nursing, home health or comprehensive outpatient rehabilitation.

Effectuation
Compliance with a reversal of the Blue Cross Medicare Advantage HMO's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Emergency Medical Condition
Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient's health;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

Emergency Services
Covered inpatient or outpatient services that are:

- Furnished by a provider qualified and appropriately licensed to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Explanation of Payment (EOP)
The statement provided to the provider when payment is made that informs the provider which procedures are being paid.

Experimental Procedures and Items
Items and/or procedures determined by not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Blue Cross Medicare Advantage HMO will consider CMS guidance if applicable, and/or determinations already made by Medicare.

Facility
Hospital and ancillary providers, which include, but are not limited to: Durable Medical Equipment (DME) suppliers and Skilled Nursing Facilities (SNFs).

Fee-for-Service Medicare
A payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare).

Grievance
Any complaint or dispute other than one involving an organization determination. Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeal process may include: waiting times in physician offices; and rudeness or unresponsiveness of customer service staff.

Hospital - Acquired Conditions
Conditions that are generally considered by CMS: (a) high cost or high volume or both, (b) result in the assignment of a case to a diagnosis related groups (DRG) that has a higher payment when present as a secondary diagnosis and (c) could reasonably have been prevented through the application of evidence-based guidelines. These criteria are subject to change by CMS.

Home Health Agency (HHA)
A Medicare-certified agency which provides intermittent skilled nursing care and other therapeutic services in the member's home when medically necessary, when members are confined to their home and when authorized by their participating physician/professional provider.

Hospice
An organization or agency, certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital
A Medicare-certified institution licensed in the State of Illinois, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Independent Physicians Association (IPA)
IPA means an Individual Practice Association, Independent Physician Association, organized Medical Group, Physician Hospital Organization or other legal entity organized to arrange for the provision of professional medical services.

Integrated Denial Letter (IDN)
The CMS and HMO approved letter to be completed and issued when the Medical Group denies a request for payment of a service already received or when the Medical Group terminates benefit coverage of a member.

Maximum Out-of-Pocket (MOOP)
The maximum amount that a member is subject to pay out-of-pocket during the calendar year for in network covered services.

Medicare
The federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A
Hospital insurance benefits including inpatient hospital care, SNF care, home health agency care and hospice care offered through Medicare.

Medicare Part A Premium
That portion of the premium required under Medicare to pay for Medicare Part A.

Medicare Part B
Medical insurance offered under Medicare that is optional and requires a monthly premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, DME, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood not covered under Part A.

Medicare Part B Premium
A monthly premium paid to Medicare to cover Medicare Part B services. Members must pay this premium to Medicare to receive covered services whether members are covered by a Medicare Advantage Plan or by Original Medicare.

Medicare Advantage (MA) Plan
A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost sharing to all Medicare beneficiaries residing in the service area covered by the Medicare Advantage Organization. A Medicare Advantage Organization may offer more than one benefit plan in the same service area. Blue Cross and Blue Shield of Illinois (BCBSIL) is a Medicare Advantage Organization and Blue Cross Medicare Advantage HMO is a Medicare Advantage Plan.

Member
The Medicare beneficiary, entitled to receive covered services, who has voluntarily elected to enroll in the Blue Cross Medicare Advantage HMO and whose enrollment has been confirmed by CMS.

Non-Contracting Medical Physician/Professional Provider or Facility
Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State of Illinois or Medicare to deliver or furnish health care services, and also being neither employed, owned, operated by, nor under contract with Blue Cross Medicare Advantage HMO or IPA to deliver covered services to Blue Cross Medicare Advantage HMO members.

Notice of Medicare Non-Coverage (NOMNC)
The CMS and HMO approved letter to be completed and issued when the Medical Group terminates benefits for skilled nursing, home health, or comprehensive outpatient rehabilitation.

Organization Determination
Any determination made by Blue Cross Medicare Advantage HMO with respect to any treatment of services that may be covered by Blue Cross Medicare Advantage HMO including, but not limited to:

- Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care or urgently needed services;
- Payment for any other health services furnished by a provider that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Blue Cross Medicare Advantage HMO;
- Blue Cross Medicare Advantage HMO's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by Blue Cross Medicare Advantage HMO;
- Reduction, or early discontinuation of a previously authorized ongoing course of treatment; and/or
- Failure of Blue Cross Medicare Advantage HMO to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Out-of-Network Provider or Out-of-Network Facility
A provider or facility that is not part of IPA's roster or normal referral pattern.

Participating Hospital
An independently contracted hospital that has a contract to provide services and/or supplies to Blue Cross Medicare Advantage HMO members.

Participating Pharmacy
An independently contracted pharmacy that has an agreement to provide Blue Cross Medicare Advantage HMO members with medication(s) prescribed by member's provider in accordance with Blue Cross Medicare Advantage HMO.

Contracted Provider
Any independently contracted professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the State of Illinois and Medicare to deliver or furnish health care services and has a written agreement to provide services directly or indirectly to Blue Cross Medicare Advantage HMO members pursuant to the terms of the Agreement.

Point of Service (POS)
A benefit option that offers Blue Cross Medicare Advantage HMO enrollees a supplemental benefit. The POS benefit option allows members the option of receiving specified services outside of the Medical Group provider network. Members will have a higher cost-sharing level when selecting an out-of-network provider for these specified services.

Post-stabilization Care Services
Post-stabilization care services defined under the Blue Cross Medicare Advantage HMO plan that generally are:

- Related to an emergency medical condition;
- Provided after a member is stabilized; and
- Provided to maintain the stabilized condition, or under certain circumstances to improve or resolve the member's condition.

Preferred Pharmacy Network
A network pharmacy that offers covered drugs to members at a lower cost-sharing level than other Participating Pharmacies.

Primary Care Physician (PCP)
Any independently contracted IPA physician who has been selected by the member to be primarily responsible for treating and coordinating the member's health care needs. A PCP may be a physician who is Board Certified or Board Eligible in Internal Medicine, Family Practice, General Practice or Geriatric Medicine.

Quality Improvement Organization (QIO)
Organizations comprising practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, Skilled Nursing Facilities (SNF), Home Health Agencies (HHA), Medicare health plans and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and Comprehensive Outpatient Rehabilitation Facility (CORFs).

Quality of Care Issue
A quality-of-care complaint may be filed through Blue Cross Medicare Advantage HMO's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration
A Blue Cross Medicare Advantage HMO member's first step in the appeal process after an adverse organization determination. Blue Cross Medicare Advantage HMO or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative
An individual appointed by a Blue Cross Medicare Advantage HMO member or other party, or authorized under state or other applicable law, to act on behalf of the member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of the member or party in obtaining an organization determination, filing a grievance or in dealing with any of the levels of the appeal process, subject to the applicable rules described at 42 CFR Part 405.

Serious Reportable Adverse Events (SRAEs)
CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. The Blue Cross Medicare Advantage HMO plan, consistent with Medicare, will also not cover hospitalizations and other services related to these non-covered procedures as defined in the Medicare Benefit Policy Manual (BPM), chapter 1, sections 10 and 180 and chapter 16, section 120.

Service Area (HMO)
A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage Plan. The geographic area for the Blue Cross Medicare Advantage HMO includes Cook, DuPage, Kane, Kendall, Lake, McHenry, and Will Counties of Illinois.

Service Area (POS)
A geographic area that is out of the HMO CMS approved counties and/or not within the MG Provider network.

Urgently Needed Services
Covered services provided that are not emergency services as defined above but that are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition.

Checking eligibility and/or benefit information and/or obtaining prior authorization is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage, including, but not limited to, exclusions and limitations applicable on the date services were rendered. If you have any questions, call the number on the member's ID card.

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