Policy Name: HMO Financial Risk Claims
Policy Number: Administrative – 67
Effective Date: 06/01/02
Revision Date: 12/01/16
Review Date: 12/01/16

Approval Signature

1/9/2017

Divisional Senior Vice President IL Health Care Delivery

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Approving Body

- ☒ Policy and Procedure Committee Date: 11/17/16
- ☒ BCBSIL QI Committee Date: 12/07/16

Details

Policy:
The HMOs of Blue Cross and Blue Shield of Illinois will electronically provide the Medical Group/Individual Practice Association or Physician Hospital Organization (hereinafter the “IPAs”), with a daily report that will require the IPA to notify the HMO of the group approval status of all claims that are the financial risk of the HMO.

Purpose/Objectives:
- To enhance timeliness and efficiency in processing claims that are the financial risk of the HMO.
- To improve provider and member satisfaction by promptly paying claims.
- To improve member satisfaction by reducing billing and collection notices.
- To allow the IPA the ability to assume financial risk.

Procedure:
1. Provider will submit a claim either electronically or on paper to the HMO for processing.
2. The HMO will process HMO facility claims for payment that have been electronically submitted on the UB04 form.
• If the hospital and IPA have an Automatic Group Approved (GAP) Agreement in place, the HMO verifies that the claim is submitted and coded correctly. The GAP code “GAP” must be entered in the Treatment Authorization field (63). A value of 1 (HMO Referral) must be entered in the Source of Admission field (15). The HMO claims processing system will also read the online provider file to verify the GAP agreement. The claim will be processed accordingly if all criteria are met.

• If the hospital and IPA do not have a GAP agreement in place, the claim will be sent to the IPA via the internet 095 report to obtain approval status.

The HMO will process all ambulance claims based on the IPA’s Group Approved/Non-Group Approved process.

3. All remaining HMO risk claims will be listed on the Internet 095 Report.

4. The IPA is required to respond within 14 calendar days to the 095 Report by checking the appropriate box for each claim listed. Guidelines for determining group approval status:
   [ ] GA – Group Approved
   Claim is group approved, services were rendered by or referred by a Primary Care Physician (PCP) or Participating Specialist Provider (PSP) affiliated with the IPA.
   [ ] NGA - Not Group Approved
   Claim is not group approved, member was not treated by or referred by a PCP or PSP affiliated with the IPA.
   [ ] MGR - Med Group Risk
   Claim is group approved and is the financial risk of the HMO but the IPA has made the determination to pay the provider.

NOTE: If the service is HMO’s risk to pay the HMO will not automatically provide a copy of the claim. IPAs can contact HMO to request a copy of the claim if they need the claim to determine approval status.

If an IPA risk claim appears on the 095 Report, check GA or NGA and in the comment field indicating the claim is IPA risk.

If the IPA assumes liability, the following rules apply:
1. The IPA must pay according to the rules of Prompt Pay legislation.
2. No units will be charged on the Utilization Management (UM) Fund.
3. The claim cannot be submitted for reinsurance.

If a member calls the HMO after 45 days from the response to the 095 Report stating the claim remains unpaid, the HMO will contact the provider. If the bill is unpaid, the HMO will pay the claim. Units will be charged and the IPA forfeits the right to challenge the UM Fund.

5. The HMO will process the claims according to the status provided by the IPA.
6. If the IPA fails to respond within 10 calendar days, the claims will default to a status of Group Approved and the HMO will process the outstanding claims.
   
   a. Appropriate units will be charged against the IPA’s UM Fund.
   
   b. Challenges to the UM Fund on claims that the IPA failed to respond to will be denied.
   
   c. All claims related to that date of service that are the IPA’s financial risk will also default to Group approved status and the IPA will be required to pay all related services.