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Claims Delegation Requirements and HMO Oversight

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

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

- The IPA’s policies and procedures for claims adjudication
- Samples of claims payments, claims denials and pended claims.
- All source documentation supporting claims payment, denial, or pended claims
HMO Claims Address
The IPAs should submit all HMO risk and non-group approved claims to the following address:

PO Box 805107
Chicago, Illinois 60680-4112

Claim Processing Procedures
- All IPA responsibility claims should be submitted directly to the appropriate IPA for payment. All HMO responsibility claims should be submitted electronically to BCBSIL.
- The member’s IPA will adjudicate claims received and offer the following dispositions:
  o Group Approved (GA) – The service was managed by one of the IPA’s physicians or referred by an IPA physician.
  o Non-Group Approved (NGA) – The service was not managed by one of the IPA’s physicians or referred by an IPA physician.
- If the HMO has a question regarding a claim, the HMO will contact the IPA. This will be done via telephone or by email. Each IPA has identified an email contact that will be used for this purpose. If the email is sent by the HMO before 2 p.m., a response is expected back from the IPA on the same day. If the email is sent after 2 p.m., the response is expected the next business day.

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

<table>
<thead>
<tr>
<th>HMO Responsibility</th>
<th>IPA Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Facility charges for:</td>
<td>- Professional Fees for:</td>
</tr>
<tr>
<td>- Inpatient stays</td>
<td>- Inpatient</td>
</tr>
<tr>
<td>- Outpatient surgery</td>
<td>- Outpatient</td>
</tr>
<tr>
<td>- Out-of-area (NGA services)</td>
<td>- In-area Emergency Room visit</td>
</tr>
<tr>
<td>- Emergency room visit</td>
<td>- Behavioral Health</td>
</tr>
<tr>
<td>- Behavioral Health</td>
<td>- Outpatient Diagnostics</td>
</tr>
<tr>
<td>- Observation Units</td>
<td>- Outpatient Rehabilitation</td>
</tr>
<tr>
<td>- Professional Emergency Admission - Charges prior to IPA notification</td>
<td>- Medical Supplies from MD office</td>
</tr>
<tr>
<td>- Professional charges for out of area emergency room visits</td>
<td>- Injections</td>
</tr>
<tr>
<td>- Hospice</td>
<td>- Immunizations</td>
</tr>
<tr>
<td>- Skilled Nursing Facility</td>
<td>- Well child care</td>
</tr>
<tr>
<td>- Skilled Nursing Facility</td>
<td>- Periodic Health Exams</td>
</tr>
<tr>
<td>- All charges for:</td>
<td>- Dental (Some dental related services, contact IPA for more details)</td>
</tr>
<tr>
<td>- Extraction of completely bony impacted teeth</td>
<td>- Orthotics/Prosthetics (O&amp;P)</td>
</tr>
<tr>
<td>- Voluntary Sterilization</td>
<td>(If referred to provider other than HMO Network Provider. Note: Some O&amp;P items are always IPA risk. Contact IPA for more details.)</td>
</tr>
<tr>
<td>- Organ Transplants (approved by HMO)</td>
<td>- Outpatient Radiation and Chemotherapy</td>
</tr>
<tr>
<td>- Transgender Services (approved by HMO)</td>
<td>- Outpatient Inhalation (Respiratory) Therapy</td>
</tr>
<tr>
<td>- Prescription Drugs</td>
<td>- Outpatient Hearing Screening</td>
</tr>
<tr>
<td>- Vision Exam/Eyewear</td>
<td>- Outpatient Ancillary Services</td>
</tr>
<tr>
<td>- Durable Medical Equipment (If referred to HMO Network Provider)</td>
<td>- Outpatient treatment</td>
</tr>
<tr>
<td>- Skilled Home Health (If referred to HMO Network Provider)</td>
<td>- Outpatient dialysis (if referred to provider other than HMO Network Provider)</td>
</tr>
<tr>
<td>- Outpatient dialysis (if referred to HMO Network Provider)</td>
<td>- Day Rehabilitation</td>
</tr>
<tr>
<td>- Orthotics/Prosthetics (O&amp;P) (If referred to HMO Network Provider. Note: Some O&amp;P items are always IPA risk. Contact IPA for more details.)</td>
<td>- ART/Infertility (If referred to provider other than HMO Network Provider)</td>
</tr>
<tr>
<td>- Medical Supplies (not from an MD office)</td>
<td>- Durable Medical Equipment (if referred to provider other than HMO Network Provider)</td>
</tr>
<tr>
<td>- Ambulance Services</td>
<td>- Skilled Home Health (if referred to provider other than HMO Network Provider or for an Ambulatory member)</td>
</tr>
<tr>
<td>- ART/Infertility (If referred to HMO Network Provider)</td>
<td></td>
</tr>
<tr>
<td>- Outpatient Private Duty Nursing for Blue Precision HMO, BlueCare Direct and Blue FocusCare</td>
<td></td>
</tr>
</tbody>
</table>

Note: This list is not all inclusive.
HMO Responsibility Claims
The HMO must determine Group Approval status on all HMO responsibility claims. There are three methods:

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

Sample IPA Approval Stamp

<table>
<thead>
<tr>
<th>HMO IPA #</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Received</td>
<td></td>
</tr>
<tr>
<td>(By IPA)</td>
<td></td>
</tr>
<tr>
<td>GA</td>
<td></td>
</tr>
<tr>
<td>NGA</td>
<td></td>
</tr>
<tr>
<td>Date Returned</td>
<td></td>
</tr>
<tr>
<td>Name or Initial</td>
<td></td>
</tr>
</tbody>
</table>

2. Through the Automatic Group Approval Process (GAP), the IPA and a hospital must sign an Automatic Group Approval Agreement with the HMO. The IPA will provide group approval status to the hospital. The hospital will bill the HMO, with the group approval status noted on the claim form, and the claim will be processed accordingly.

3. The HMO will make available to the IPA the daily 095 report via the Internet. This report can be accessed at https://providers.hcsc.net/providers/il_login.html. Each IPA user must have a secure sign on. The Provider Network Consultant should be contacted to facilitate this. If technical assistance is needed after the sign-on is received, contact our Help Desk at 312-653-6675 and ask for the Internet Help Desk through Blue Access.

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

The IPA should download the data regularly for historical documentation purposes. The data definitions are located on the Internet site.
HMO Online (095) Claims Report Application

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

HMO Online (095) Claims Report Application
The functionality of the HMO Claims Report includes the ability to view and respond with the group approval status of claims that are the financial risk of the HMO. Various reports may be downloaded, including open claims, closed claims and a data definition report. The following instructions provide step by step directions on how to use the application. Refer to the Troubleshooting Tips found in this section if additional assistance is needed.

1. The Login page will be displayed.

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

   User ID

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

   Password

4. Click on the ‘Login’ button once using

   Login

5. Select the HMO Claims Report link.
6. Click on 095-Request for Group Approval Status List

HMO Claims

Choose the following reports to get more HMO Claim Information.

095 - Request for Group Approval Status List

7. Select an IPA, if you have access to more than one, in the drop down box.
8. You should arrive at this search window. You have multiple options to search for open or closed claims. To see the entire report you may click on display.
9. Alternatively, you may enter a search argument such as a ‘Report Date Range’ by clicking on the drop down box in ‘Report Date Range’ and then click ‘Display’ to see the list.
10. You may also enter a search argument in the ‘Approval Status’ drop down, such as all open claims waiting for approval, OP. If no status is selected, all claims will be displayed when you click on the ‘Display’ button.
11. Scroll down and the list or index report will appear. If all claims were selected as in the example, the status column will display the disposition of the claim. To view or provide an approval status, click the DCN number on the left column.

<table>
<thead>
<tr>
<th>#</th>
<th>DCN Number</th>
<th>Report Date</th>
<th>Patient Name</th>
<th>Subscriber ID</th>
<th>From Date - To Date</th>
<th>Proc Ind</th>
<th>Provider Name</th>
<th>Status</th>
<th>Sub SSN</th>
<th>Int Ref Nbr</th>
</tr>
</thead>
</table>
After clicking on the DCN on the index page, you will arrive at the update page (example on next page).

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

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

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

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

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

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

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

- **User:**
  Will be pre-filled with the name of the person who has signed on.
13. To return to the listing of claims click on the breadcrumb, 095-Request for Group Approval Status Report:

   Home > 095-Request for Group Approval Status Report > 095-Request for Group Approval Claim Update
14. From the list window, if you click on a DCN for a claim that has already been updated by a member of your staff, you will arrive at a ‘read-only’ claim window.
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 and the name of your IPA
7. For HMO Illinois®, Blue Advantage HMO℠, Group Blue Precision HMO℠ (Group number starting with “R”) and BlueCare Direct℠ (Groups number starting with an “A”) products: email the claim to hmoiqueryrequests@bcbsil.com. For the Individual Retail Blue Precision HMO℠ and Blue FocusCare℠ (Group number starting with an “I”) product: email the claim to retailbphmoilcauhcmassistance@hscil.com.
Send only one claim per email.

Note: If you are changing the status from group-approved to not group-approved, you must send your request to change the status within five calendar days of the original submission.

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

What if I can’t access the Web page?
Each IPA has identified an internal security officer. Discuss your issue first with your internal security officer. If you continue to have an issue, call the BCBSIL Help Desk at 312-653-6675 for Blue Access help.

What If I forgot my password or my sign on?
Call the BCBSIL Help Desk at 312-653-6675 for Blue Access help.

What if BCBSIL is having technical problems and the Web page is not available for us to work our claims?
If there are system issues and the Web page is unavailable for more than 24 hours, the HMO will make accommodations as needed.

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

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

Where do I report other problems or if I have questions?
Please contact your Provider Network Consultant.
To Download Report

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

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

   a) Netscape: You will probably receive a Web browser message box indicating an unknown file type.

   ![Unknown File Type]

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

   ![File Download]
3. Depending on your browser,
   a) Netscape: Click on the ‘Save File’ button.
   b) Internet Explorer: Click on the ‘Save this File to Disk’ radio button and click on ‘OK’.

4. The ‘Save As’ window will appear.

![Save As Window]

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

5. Verify the location where the file will be saved by reviewing the ‘Save in’ field at the top of the window. You can change this location as desired.

6. Click on the ‘Save’ button.

7. The file will be saved in a .txt format to the location selected (step 19).
Additional Functionality

Data Definition Table

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

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

   ![Data Definition Table](image)

3. You can close the data definition pop up window in one of two ways:
   a) Click on the ‘Close’ button at the bottom of the window.
   b) Click on the ‘x’ button at the top of the window.

Clearing Search Form

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

2. The search form will be displayed. However, the results report that was displayed will not change.
Importing Downloaded File – Microsoft Access
The following includes the steps to import a downloaded file into Microsoft Access. At many steps, pages in parentheses will refer you to the specific section in this document that discusses the page’s elements in full detail.

Assumptions
- User has a database open in Microsoft Access.

Instructions
1. Open the database, in which you wish to import the data.
2. From the top menu, select ‘File – Get External Data – Import.’
3. Find and select the downloaded file you wish to import (confirm you are looking in the right directory and that you have file type selected as text files.)
4. Click the 'Import' button.

5. Select the 'Delimited' file type radio button.

6. Click the 'Next' button.

7. Select the Semicolon radio button for the delimiter.
8. Check the First Row Contains Field Names check box.

9. Click the ‘Next’ button.

10. Select where you want to import the data. You can:
   a) import to a new table; or
   b) select an existing table

11. Click the ‘Next’ button.

12. **Optional step** – if desired or necessary, you may specify information about your fields (by selecting the options presented).

13. Click the ‘Next’ button.

14. Select your primary key or allow Access to do it for you by selecting the appropriate radio button.

15. Click the ‘Next’ button.

16. Confirm the table name is where you want to import the file.

17. Click the ‘Finish’ button.

18. You will receive an information success box that your data was imported successfully.
Importing Downloaded File – Microsoft Excel

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

**Assumptions**
- User has a database open in Microsoft Excel.

**Instructions**

1. Open the file, in which you wish to import the data.
2. From the top menu, select ‘Open’.
3. Find the downloaded file you wish to import (confirm you are looking in the right directory and that you have file type selected at text files).
4. Click the ‘Open’ button. Select the ‘Delimited’ file type radio button.
5. Click the ‘Next’ button

6. Select the semicolon check box for the delimiter.

7. Click the ‘Next’ button.

8. Select the column data format that you wish to use (general, text, date or do not import) for each column.

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

9. Click the ‘Finish’ button.

10. Your data will be imported to your open Excel spreadsheet.
IPA Responsibility Claims
Payment should be made on valid referral bills within 30 days of receipt by the IPA, per the Medical Service Agreement.

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

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

- Provider responsibilities
- Agreed upon compensation, at least in general terms
- Agreement to seek compensation solely from the IPA, not from the member or HMO
- Agreement to participate in quality of care review activities as requested by the IPA including allowing access to medical records for HEDIS reporting and other HMO quality improvement initiatives
- Professional liability insurance coverage as specified in the Medical Service Agreement (MSA)
- Agreement to preserve patient confidentiality; and
- Agreement to accept the PPO fee schedule for referred or emergency services as specified in the Medical Service Agreement.

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

Out-of-Area Claims
Out-of-area is defined as being more than 30 miles away from the IPA or IPA-affiliated hospital. If an IPA refers and approves services for a member that is more than 30 miles away, the standard financial responsibility applies.

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

The HMO pays all charges for outpatient, physician, ancillary and hospital services for a resulting admission, provided services meet the Out-of-Area Emergency Criteria. 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.

No units are charged against the Utilization Management Fund for these hospital admissions. Whenever possible, the IPA should attempt to bring the member back into the service area when the patient is stable and it is medically appropriate. Admission to a rehabilitation facility out-of-area from the acute hospital setting is not considered an emergency and is therefore not coverable.

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

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

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

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

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

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

Membership

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

Benefits

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

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

Claims

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

Questions

HMO providers should contact their IPA or call the customer service number on the back of the Member’s ID card if more information is needed about guest membership.
Out-of-Plan Claims
Out-of-Plan is defined as being within 30 miles of the service area of the IPA but not group-approved.

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

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

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 Plan 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.

Emergency Room or Emergency Admission Claims
The IPA is financially responsible to pay physician and other professional charges for all in-area emergency room services, subject to the HMO’s determination that the services meet the definition of an emergency medical condition.

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

Note: More information can be found in the Utilization Management Plan Section of this manual regarding how to perform Utilization Management for these types of admissions.
Infertility Claims
All Infertility claims are the HMO’s responsibility with one exception. If the IPA personnel refers a member to a non-contracting Infertility provider, the professional charges become the IPA’s financial responsibility. When applicable, all units will be charged against the IPA’s Utilization Management (UM) Fund if a non-contracting provider is used. Normally, no units are charged against the fund.

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

Winfertility, Inc.
1 American Lane – Terrace Level
Greenwich CT 06831

Covered Services Expense Limitations – Out of Pocket Maximum (OPX)
A member may have a Covered Services Expense Limitation, otherwise known as an “out-of-pocket maximum.” This amount may vary per Employer Group. Refer to the HMO Benefit Matrix for additional information.

The HMO will track the member’s accumulated liability (that includes copayments, deductibles and co-insurance, as applicable). When the member has reached their OPX, no further copayments should be collected. The HMO provides a report (Members OPX Met List) of members that have met their OPX limit. This report can be accessed at https://providers.hcsc.net/providers/il_login.html. Contact your Provider Network Consultant if you need access to the portal. Once a member has met the OPX limit, the member’s benefit plan will be changed to reflect a zero copayment plan.

The IPA will need to submit a weekly file to the HMO that includes information on all for which a copayment was collected or refunded. The file must be in the HMO required format, and will be submitted using an SFTP server.

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

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

The IPAs will submit the OPX files via a SFTP server. Below is a list of software vendors that some of our trading partners utilize to submit data transactions to the HMO.

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

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

1. Please use the correct file name that was included in the e-mail regarding the OPX password. The file name should be in ALL CAPS

2. Sender ID @pSENDER_ID - Please use the Sender ID that was included in the e-mail regarding the OPX password.

3. Unique Record ID @p RECORD_INFO – The Record ID is created by the IPA. Please populate this field with a unique identifier for each record. It is imperative that the Record ID is unique for each record. If a file is submitted with a duplicate Record ID the file will be rejected as a duplicate.

4. The OPX file is not a cumulative file please only submit the copay information one time.
5. Accumulator Amount @pMEAC_AMT1 – the copay should be populated with a decimal (example 24.00)

6. Do not submit zero copays

7. If only the dependent is assigned to an IPA the subscriber last name can be found on HMO eligibility list

8. Make sure all fields are populated with the appropriate information. If one record is incorrect the entire file will be rejected

9. Only submit one file per day per IPA

10. When a file is submitted it will immediately disappear, do not resubmit the file multiple times

11. If a copayment is refunded to the member, the refund must be submitted as a negative copay in the OPX file submission.

12. If the IPA discovers an error in submission of a copay, a negative adjustment should be submitted to correct the error.

   • Additional Information regarding SFTP Communications and the OPX file layout can be found on the IPA Secure Access Portal. The Web address for the portal is: https://bcbsilezaccess.com/ipa_portal/default.aspx. The documents can be found under the Provider Network Management tab in the HMO Out of Pocket (OPX) Maximum Information folder. If you need access to the portal, contact your Provider Network Consultant.

**Process Used by the HMO to Recover Overpayments**

If an HMO overpayment is identified by the IPA, the IPA must notify the HMO within 10 calendar days. The IPA must refund any amounts due to the HMO within 30 calendar days, unless otherwise instructed by the HMO in writing. The HMO reserves the right to deduct the amounts owed from current or future payments due to the IPA.
Reinsurance Claims
The HMO reinsures an increasing portion of the medical benefit costs incurred by the IPA, as defined in the Medical Service Agreement (MSA). Reinsurance claims are calculated based on the Quality Improvement and Reinsurance Activity (QIRA) data submitted by the IPA to the HMO.

QIRA data must meet the submission requirements as defined in the MSA, this manual and in the QIRA Companion Guide located on the IPA Secure Access Portal at https://bcbsilezaccess.com/ipa_portal/default.aspx.

IPAs will receive a monthly report via the Verscend (Verisk Health) portal showing which claims exceed the predetermined stop loss amount, and are therefore eligible for reimbursement. The IPAs will also receive reports via the same portal that indicates which claims will not be considered for reinsurance. The Verscend portal can be accessed at https://pophealthproducts.verscend.com. Contact your Provider Network Consultant if you need access to the portal.

The HMO will reimburse the IPA a portion of the IPA incurred costs, according to the reinsurance process document located on the IPA Access Portal at https://bcbsilezaccess.com/ipa_portal/default.aspx. This payment will be made via the monthly capitation payment.

Reinsurance Calculation
- Catastrophic claims will not be considered for reinsurance.
- IPA risk claims and encounter data should only include newly paid/adjudicated claims. IPAs will be notified of apparent duplicate claims which will not be considered for reinsurance unless they are corrected in subsequent monthly submissions.
- Claims which are the HMO’s financial responsibility to pay will not be considered for reinsurance, even if the IPA has paid the charges.
- Coordination of Benefits with a Primary Payer and/or Medicare must be concluded prior to submitting risk claims and encounter data, and the paid amounts should be net of COB; the HMO will not consider capitated services when the HMO is not primary.
- Refer to the MSA and the reinsurance process documentation that can be found on the IPA Secure Access Portal. The Web address for the portal is: https://bcbsilezaccess.com/ipa_portal/default.aspx. The documents can be found under the Provider Network Management tab in the HMO Reinsurance Information folder. If you need access to the portal, contact your Provider Network Consultant.

Threshold Calculation
In order to be eligible for reinsurance, the IPA must pay IPA-responsible charges incurred by any one member in any one Agreement Year up to the threshold indicated in the MSA; the threshold may change on an annual basis. The HMO will then pay the IPA for 80%, 90% or 100% of additional eligible charges that exceed the threshold incurred for that Member in that Agreement Year, according to the terms outlined in the MSA. The table below outlines an example based on a reinsurance threshold of $15,000.00.

<table>
<thead>
<tr>
<th>Claims Payment</th>
<th>IPA Responsibility</th>
<th>HMO Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,000.00 in claims</td>
<td>$15,000.00</td>
<td>(None)</td>
</tr>
<tr>
<td>The IPA has now met the stop-loss, and is at the 80% reimbursement level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$150,000.00 more in claims</td>
<td>$30,000.00 20%</td>
<td>$120,000.00 80%</td>
</tr>
<tr>
<td>$45,000.00 total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The IPA has now spent over $37,500.00, and is therefore is now at the 90% reimbursement level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$325,000.00 more in claims</td>
<td>$32,500.00 10%</td>
<td>$292,500.00 80%</td>
</tr>
<tr>
<td>$77,500.00 total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The IPA has now spent over $75,000.00, and is therefore is now at the 100% reimbursement level.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questions/Problems
If there are questions or problems concerning reinsurance, please contact your Provider Network Consultant.
Non-Capitated Services (Catastrophic Claims)
There are several conditions that the HMO considers catastrophic. Group-approved services related to these conditions that are usually the IPA’s responsibility become the HMO’s responsibility. These situations are:
- Voluntary sterilization
- Extraction of completely bony impacted teeth
- Organ transplants, related pre-surgical laboratory and diagnostic tests performed by the designated transplant facility, and follow-up within 365 days of the transplant, provided IPA obtained prior approval for organ transplant from the HMO
- Transgender services, provided the IPA obtained prior written approval from the HMO. Outpatient Behavioral Health services remain the IPA’s financial liability.

The IPA has two options:

1. The HMO will reimburse the IPA at the lesser of the amount paid or at the BCBSIL PPO Schedule of Maximum Allowance. The claims must be stamped “Group-Approved” and submitted on the Catastrophic Claims Form to the HMO Claims Department. (See the next page for the sample Catastrophic Claims Form)

2. The IPA also has the option to have the HMO pay the provider directly at the lesser of billed charges or the BCBSIL PPO Schedule of Maximum Allowance. Each claim must be stamped “Group-Approved.” In addition, a note indicating the type of claim (voluntary sterilization, extraction of completely bony impacted teeth, organ transplant-related, or transgender service) must be written by the stamp. Use black or blue ink only, but do not use a highlighter pen.
### Catastrophic Claim Form

**HMO Illinois®, Blue Advantage HMO℠, Blue Precision HMO℠, BlueCare Direct℠ and Blue FocusCare℠**

Medical Group/IPA Name: _____________________________________________________________
Medical Group/IPA Number: __________________________________________________________
Patient Name: _____________________________________________________________________
Group/ID #: ______________________________________________________________________

Payee Name: ______________________________________________________________________
Payee Address: _____________________________________________________________________
Payee City/State/Zip code: ___________________________________________________________

<table>
<thead>
<tr>
<th>DATE OF SERVICE</th>
<th>PROVIDER</th>
<th>DIAGNOSIS</th>
<th>TYPE OF SERVICE</th>
<th>BILLED AMOUNT</th>
<th>PAID AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
</tbody>
</table>

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

The PDC Challenge Form, as described in the policy, can be found on the IPA Secure Access Portal at https://bcbsilezaccess.com/IPA_portal/default.aspx. Contact your Provider Network Consultant if you need access to the portal.

Compliance with HMO Data Collections Requirements
The IPA must comply with Quality Improvement and Reinsurance Activities (QIRA) reporting by providing a file containing all data elements required by the HMO and in a format and timeframe acceptable to the HMO. Additional information can be found on IPA Secure Access portal at https://bcbsilezaccess.com/IPA_portal/default.aspx. If you do not have access, contact your Provider Network Consultant.

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

In addition, the IPA must submit a quarterly summary report of claims/encounters submitted and adjudicated for each capitated and employed provider. Additional information related to this report is found in the Submission Grid Overview document in the HMO Medical Service Agreement Highlight and Process Summary section of this manual.
Affordable Care Act (ACA) Grace Period Process (Blue Precision HMO SM, BlueCare Direct SM and Blue FocusCare SM)

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

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

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

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

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

<table>
<thead>
<tr>
<th>APTC Three Month Grace Period Process</th>
<th>First Month</th>
<th>Second and Third Months</th>
<th>Fourth Month</th>
<th>Premium is Unpaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• IPA can retrieve the Grace Period Report</td>
<td>• Capitation will continue to be paid by the HMO.</td>
<td>• If the outstanding premium is not paid in full prior to the first day of the fourth month, the coverage will be cancelled retroactively to the last day of the first month of the grace period. <em>(The notification must include HMO required language.)</em></td>
<td>• Premium is Unpaid</td>
<td>• If the outstanding premium is not paid in full prior to the first day of the fourth month, the coverage will be cancelled retroactively to the last day of the first month of the grace period. <em>(The notification must include HMO required language.)</em></td>
</tr>
<tr>
<td>• Capitation will be paid to the IPA, irrespective of unpaid premium balances.</td>
<td>• All eligibility reports and verification systems established by the IPA need to inform providers that the member is in a grace period. <em>(The notification must include HMO required language.)</em></td>
<td>• Capitation will not be deducted for month one of the grace period</td>
<td>• Capitation paid during the second and third months of the grace period will be retroactively deducted.</td>
<td>• Capitation paid during the second and third months of the grace period will be retroactively deducted.</td>
</tr>
<tr>
<td>• The IPA follows standard procedures for all services and referrals.</td>
<td>• Referrals for services must include notification that the member is in a grace period, and the payment for the cost of the services rendered may become the member’s responsibility. <em>(The notification must include HMO required language.)</em></td>
<td>• All pended claims should be processed and denied.</td>
<td>• All pended claims should be processed and denied.</td>
<td>• All pended claims should be processed and denied.</td>
</tr>
<tr>
<td>• Referrals that extend beyond the first month of the grace period must include notification to the referring provider that the member is in a grace period and services may become the member’s liability.</td>
<td>• IPA pends claims for authorized services rendered during the second and third months.</td>
<td>• Provider may request payment for denied claims from the member for services rendered in months 2 and 3.</td>
<td>• Provider may request payment for denied claims from the member for services rendered in months 2 and 3.</td>
<td>• Provider may request payment for denied claims from the member for services rendered in months 2 and 3.</td>
</tr>
<tr>
<td>• Group approved claims should be processed according to the member’s benefits.</td>
<td>• Providers must be notified of the claim status via an electronic or printed communication.</td>
<td></td>
<td>• Providers must be notified of the claim status via an electronic or printed communication.</td>
<td>• Providers must be notified of the claim status via an electronic or printed communication.</td>
</tr>
<tr>
<td></td>
<td>• The communication must state the member is in a grace period and claims have been pended.</td>
<td></td>
<td>• The notification must include the information found on the letter template: “Grace Period Months 2 and 3 Provider Notification Template – Claims Payment Status.” <em>(See template at end of this section.)</em></td>
<td>• The notification must include the information found on the letter template: “Grace Period Months 2 and 3 Provider Notification Template – Claims Payment Status.” <em>(See template at end of this section.)</em></td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Non-APTC HMO Members Grace Period</th>
<th>First Month</th>
<th>Second Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium is unpaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If premium balance is not paid in full by the end of month two, the policy is remains cancelled, retroactive to the first day of month two of the grace period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Process and deny claims beginning with dates of service on the first day of month two and thereafter.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provider may request payment for denied claims from the member.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Member pays Premium               |             |              |
| • If member pays the premium balance by the end of month two, the member will be reinstated with no break in coverage. |             |              |
| • Within 10 days of notification that the member has paid their premium in full, the IPA should identify all process all pended claims. |             |              |
HMO Grace Period Report

The HMO will provide the IPA with a daily Grace Period Report. The report will be electronically posted to the HMO’s secure Internet site. Once a member has entered the first month of the grace period or transitioned to the second and third months of the grace period, the member will be added to the report.
## HMO Grace Period Report Data Definition – File Layout

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Data Type</th>
<th>Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROV_ID</td>
<td>Number</td>
<td>3</td>
<td>Contracting Entity Number</td>
</tr>
<tr>
<td>PROV_SEQ_NBR</td>
<td>Number</td>
<td>3</td>
<td>Medical Group Number</td>
</tr>
<tr>
<td>GRP_ID</td>
<td>Character</td>
<td>9</td>
<td>Group Id</td>
</tr>
<tr>
<td>FIRST_NM</td>
<td>Character</td>
<td>20</td>
<td>Member First Name</td>
</tr>
<tr>
<td>LAST_NM</td>
<td>Character</td>
<td>20</td>
<td>Member Last Name - Could differ from subscriber Last Name</td>
</tr>
<tr>
<td>MBR_ADDR_LN_1</td>
<td>Character</td>
<td>30</td>
<td>Member Street Address 1</td>
</tr>
<tr>
<td>MBR_ADDR_LN_2</td>
<td>Character</td>
<td>30</td>
<td>Member Street Address 2</td>
</tr>
<tr>
<td>MBR_ST_NM</td>
<td>Character</td>
<td>20</td>
<td>Member City Name</td>
</tr>
<tr>
<td>MBR_ST_PRVNC_CD</td>
<td>Character</td>
<td>2</td>
<td>Member State</td>
</tr>
<tr>
<td>MBR_POSTI_CD</td>
<td>Character</td>
<td>9</td>
<td>Member Zip Code</td>
</tr>
<tr>
<td>DOB</td>
<td>Date</td>
<td>10</td>
<td>Date of Birth of Member (MM-DD-YYYY)</td>
</tr>
<tr>
<td>MBR_GNDR_CD</td>
<td>Character</td>
<td>1</td>
<td>Member Gender Code (F-Female, M-Male)</td>
</tr>
<tr>
<td>REL_CD</td>
<td>Character</td>
<td>3</td>
<td>Member Relationship Code (SUB-Subscriber, SPS-Spouse, DEP-Dependent)</td>
</tr>
<tr>
<td>SUB_ID_NBR</td>
<td>Character</td>
<td>12</td>
<td>Subscriber Number</td>
</tr>
<tr>
<td>SUB_LAST_NM</td>
<td>Character</td>
<td>20</td>
<td>Subscriber (&quot;Family&quot;) Last Name</td>
</tr>
<tr>
<td>SUB_PHONE_NBR</td>
<td>Character</td>
<td>10</td>
<td>Subscriber Telephone Number</td>
</tr>
<tr>
<td>ITUA_IND</td>
<td>Character</td>
<td>1</td>
<td>Qualified Native American / Alaskan (Y/N)</td>
</tr>
<tr>
<td>MEMBER_SUBSIDY_IND</td>
<td>Character</td>
<td>1</td>
<td>Member Receives APTC (Y/N)</td>
</tr>
<tr>
<td>GRC_PRD_STA_CD</td>
<td>Character</td>
<td>3</td>
<td>Grace Period Status Code (GPI - Initiated; GPE - Extended; GRI - Reinstated; GPC - Cancelled)</td>
</tr>
<tr>
<td>CLMS_PAY_THRU_DT</td>
<td>Date</td>
<td>10</td>
<td>Claims Pay Through Date (MM-DD-YYYY)</td>
</tr>
<tr>
<td>GRACE_PER_EFF_DT</td>
<td>Date</td>
<td>10</td>
<td>Effective date of the Grace Period Status Code (MM-DD-YYYY)</td>
</tr>
</tbody>
</table>
Grace Period Months 2 and 3 Provider Notification Template - Claims Payment Status

Date

PROVIDER NAME

PROVIDER ADDRESS

PROVIDER CITY STATE ZIP

Claim Information

Patient Name

Claim #

Group/ID # Service

Date Prov. Pat. No.

Subject: Grace period notification about your patient

Dear <PROVIDER>:

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

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

What this means to you

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

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

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

Sincerely,

Your Customer Advocate