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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

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 agreed in writing to pay for the services if they are not covered.

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.html

  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 claims reports

Instructions:
1. Select **HMO Claims**

2. Click on 095-Request for Group Approval Status Report

> **HMO Claims**
>
> **Choose the following reports to get more HMO Claim Information.**
>
> **095 - Request for Group Approval Status List**

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

ABC Medical Group
ABC Medical Group
XYZ Medical Group
XYZ Medical Practice
MOT Health Center
MOT Health Group
BEV Health Centers
BEV Health Partners
BEV Health Practice
BLT Women's Health
BLT Women's Health Group
BLT Women's Health Practice

- 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

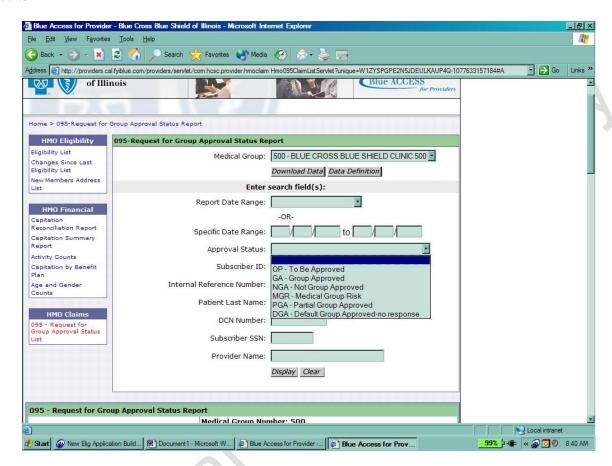| #	DCN Number	Report Date	Patient Name	Subscriber ID	FromDate - ToDate	Prc Ind	Provider Name	Status	Sub SSN	Int Ref Nbr
3	111111111111	11/08/2011	Jane Doe	2222222222	10/15/2011 10/20/2011		ABC Medical Group	GA	111-22-3333	99351034
4	111111111111	11/08/2011	John Doe	2222222222	10/22/2011 10/31/2011		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 full.

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

  Comments:

  - Enter up to 200 alpha/numeric characters.

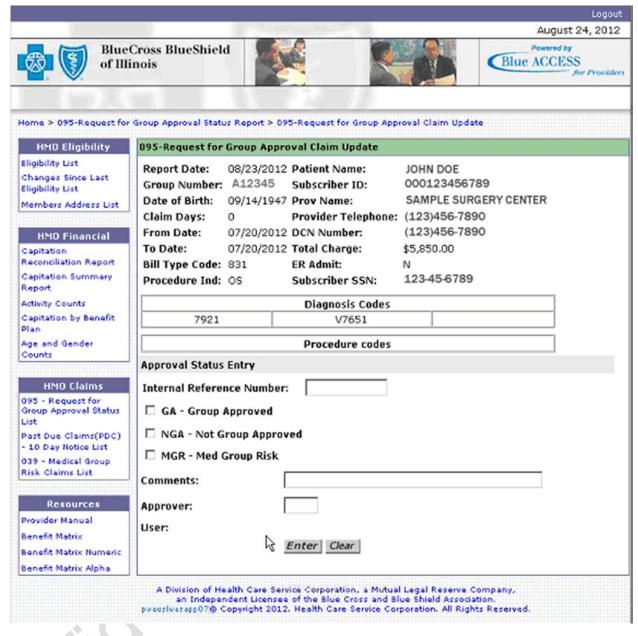 - To be used when you want to send us information.

  Approver:

  - Three alpha/numeric characters.

  - For IPA internal use to document who submitted group approval status.

  User:

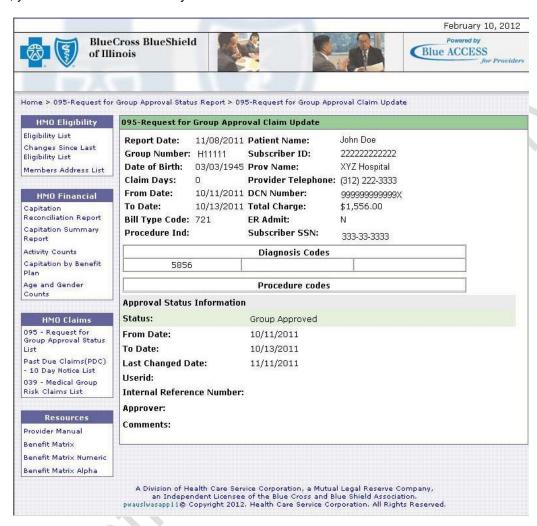 - Will be pre-filled with the name of the person who has signed on.

- 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.

February 10, 2012

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

HMO Eligibility

Eligibility List
Changes Since Last Eligibility List
Members Address List

HMO Financial

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

HMO Claims

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

Resources

Provider Manual
Benefit Matrix
Benefit Matrix Numeric
Benefit Matrix Alpha

095-Request for Group Approval Claim Update

Report Date:	11/08/2011	Patient Name:	John Doe
Group Number:	H11111	Subscriber ID:	222222222222
Date of Birth:	03/03/1945	Prov Name:	XYZ Hospital
Claim Days:	0	Provider Telephone:	(312) 222-3333
From Date:	10/11/2011	DCN Number:	999999999999X
To Date:	10/13/2011	Total Charge:	$1,556.00
Bill Type Code:	721	ER Admit:	N
Procedure Ind:		Subscriber SSN:	333-33-3333

Diagnosis Codes		
5856		

Procedure codes

Approval Status Information

Status:	Group Approved
From Date:	10/11/2011
To Date:	10/13/2011
Last Changed Date:	11/11/2011
Userid:	
Internal Reference Number:	
Approver:	
Comments:	

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.

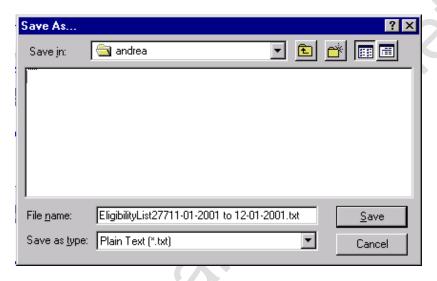### To Download Report

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

    Download Data

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.

Save As...	? X
Save in: andrea	
File name: EligibilityList27711-01-2001 to 12-01-2001.txt	Save
Save as type: Plain Text (*.txt)	Cancel

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).
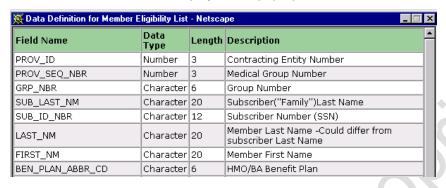
Additional Functionality
Data Definition Table

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.

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 not change.

BlueCross BlueShield of Illinois
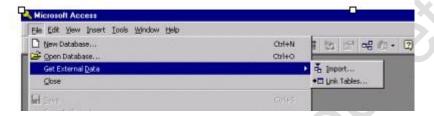
Importing Downloaded File – Microsoft Access

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.
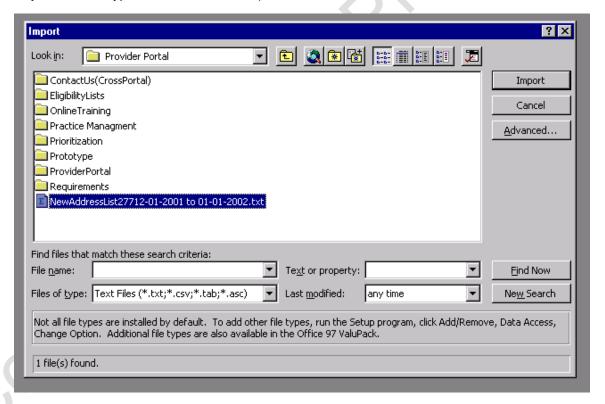
Assumptions:
- User has a database open in Microsoft Access.

Instructions:
1. Open the database into which you wish to import the data.

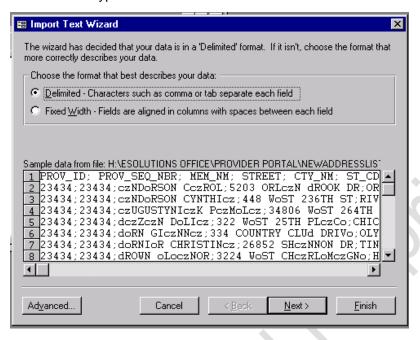2. From the top menu, select **File – Get External Data –Import.**

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).
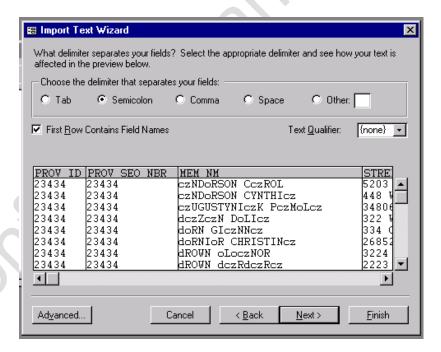
1. Click the **Import** button.

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.
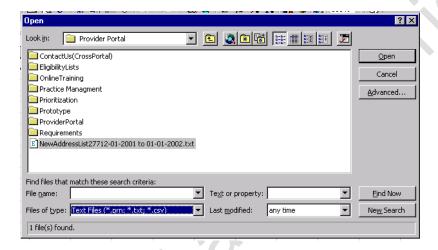
Importing Downloaded File – Microsoft Excel
The following includes the steps to import a downloaded file into Microsoft Excel. At many steps, pages in parentheses will refer you to the specific section in this document that discusses the page's elements in full detail.
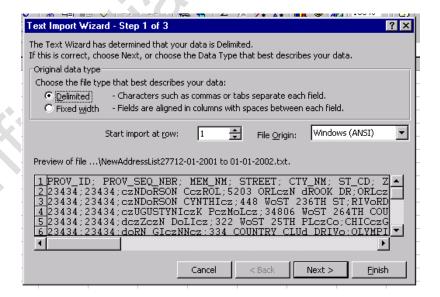
Assumptions:
• User has a database open in Microsoft Excel.

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).
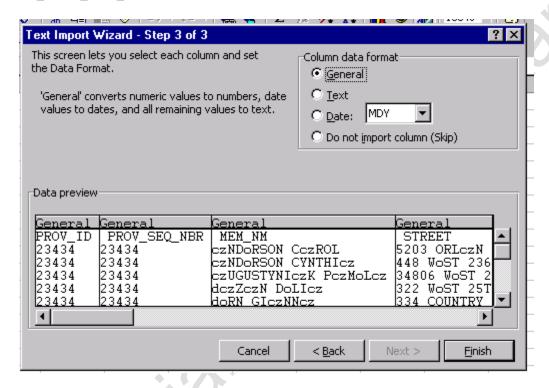

• Click the **Open** button. Select the Delimited file type radio button.

BlueCross BlueShield
of Illinois

- 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.

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. TransAct RX 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

- The IPA's policies and procedures for 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

- IPA agrees to participate in Quality Improvement and Reinsurance Activities (QIRA) and comply with QIRA reporting requirements by providing a monthly data file containing all data elements required by the HMO and in a format acceptable to the HMO.
    - IPA agrees to submit complete (as verified by HMO analysis) QIRA data. Data required to be reported includes, but is not limited to, laboratory data, all physician services (including capitated services), emergency room, ancillary and any other services that are the payment responsibility of the IPA.
    - 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 QIRA 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.

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 the IPA
Quality Improvement and Reinsurance Activities Reporting (QIRA)	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 QIRA data submitted by IPA
Claims - Organization Determinations/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 Encounters 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 Claims Processing Policies and Procedures	Annually	
Copy of Notice of Denied Payment – Member Denial Letter	Annually	
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

BlueCross BlueShield
of Illinois

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® located on the BCBSIL website http://www.bcbsil.com/medicare/mapd_provider.html 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 an HAC, 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	MS-DRG
Surgery on Wrong Body Part	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.

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