BLUE CROSS AND BLUE SHIELD OF ILLINOIS
POLICY

DEPARTMENT: Network Provider Performance	
POLICY NUMBER: Administrative 42	**POLICY TITLE:** Past Due Claim (PDC) Process
EXECUTIVE OWNER: Executive Director, Provider Performance	**BUSINESS OWNER:** Manager, Provider Performance
ORIGINAL EFFECTIVE DATE (IF KNOWN): 09/01/1999	**COMMITTEE APPROVAL DATE:** 10/24/2024

I. SCOPE

This Policy applies to Blue Cross and Blue Shield of Illinois (BCBSIL) Health Management Organization (HMO), and for the following lines of business and products:

Line of Business / Product Scope / Plan Scope/Contract Number (if applicable)	In Scope [x]
HMO Commercial	x
HMO IFM	x
PPO Commercial	
PPO Exchange	

II. PURPOSE

- To enhance timeliness and efficiency when processing claims that are the IPA's financial risk.
- To improve member satisfaction by promptly processing claims and eliminating service-related issues.
- To improve communication between the HMOs and the IPAs.

III. POLICY

The HMOs of Blue Cross and Blue Shield of Illinois (BCBSIL) will pay eligible charges on claims that are the Medical Group/Individual Practice Association or Physician Hospital Organization (hereinafter the "IPAs"), risk to pay if the claim has not been appropriately processed by the IPA.

IV. CONTROLS/MONITORING

The following criteria must be met to process a claim as a Past Due Claim (PDC):

1. Membership Status:
   - The member must have been assigned to a valid IPA at the time services were rendered.

2. Bill or Statement Received by Member:
    - The claim is processed on HMO claim system via the 039 process and forwarded to the correct IPA more than 30 calendar days previous to member's bill/statement, or
    - The bill/statement date is more than 45 calendar days old from date of service,or
    - The claim is currently in collection status.
3. Statement Status:
    - The date of service should be more than 45 calendar days and,
    - The claim in question should have a statement date that is less than 30 calendar days old,
    - Balance forward statements must be thoroughly reviewed and not solely used for PDC process. Balance forward statements may reflect copay amounts which are not eligible under the PDC process.

Line of Business and/or Area	Control Requirements
HMO	Controls are detailed in the ***BCBSIL Procedure Flow*** .

V. RELATED DOCUMENTS

Administrative 42A - Past Due Claim (PDC) Process

VI. IMPACTED BUSINESS AREAS

Impacted areas include:

- HMO Commercial and HMO Exchange Service Centers
- HMO Network
- HMO Customer Assistance Unit
- Provider Network Financial Management

VII. POLICY REVIEWERS

Person Responsible for Review	Title	Date of Review
Jessica Whaley	HMO Provider Network Consultant	10/08/2024

VIII. POLICY REVISION HISTORY

Description of Changes	Revision Date
Revised Policy header	10/08/2024

IX. POLICY APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
Provider Performance	Geoff Guiton	Executive Director, Provider Performance	10/18/2024
BCBSIL P&P Committee			10/24/2024

BLUE CROSS AND BLUE SHIELD OF ILLINOIS
PROCEDURE

DEPARTMENT: Network Provider Performance	
PROCEDURE NUMBER: Administrative 42A	**PROCEDURE TITLE:** Past Due Claim (PDC) Process
EXECUTIVE OWNER: Executive Director, Provider Performance	**BUSINESS OWNER:** Manager, Provider Performance
ORIGINAL EFFECTIVE DATE (IF KNOWN): 09/01/1999	**COMMITTEE APPROVAL DATE:** 10/24/2024

I. SCOPE

This Policy applies to Blue Cross and Blue Shield of Illinois (BCBSIL) Health Management Organization (HMO), and for the following lines of business and products:

Line of Business / Product Scope / Plan Scope/Contract Number (if applicable)	In Scope [x]
HMO Commercial	x
HMO IFM	x
PPO Commercial	
PPO Exchange	

II. POLICIES IMPLEMENTED BY PROCEDURE

This Procedure implements the following Policy(ies):

Policy Name	Policy Number
Past Due Claims Process	Administrative 42

III. PROCEDURE

1. An HMO Member or a representative from the HMO marketing office acting on behalf of the member contacts the Service Center regarding an unpaid bill that is the financial risk of the IPA.

2. The Customer Advocate (CA) verifies claim history to ensure that the claim was adjudicated correctly.

3. If review of claim history shows no claim payment or denial by the HMO and the claim was sent to the correct IPA, the CA should initiate the web based PDC process. The PDC notice(s) is posted daily on the HMO Provider Portal at: https://providers.hcsc.net/providers/il_login.html. The IPA has 10 calendar days to respond via web based PDC process with a valid response whereby acceptable valid responses include:

    a. Paid by site with check number or with a capitation payment without check number (if a capitation payment, then check number not needed),

b. Paid indicating a future paid date with check number/capitation payment date. If a check number is not available, mark the 'other' box and indicate in the comments field the future paid date. The future paid date must be within 14 calendar days of the PDC due date,

c. Denied for timely filing,

d. Denied for no authorization (Non-Group Approved-NGA),

e. Group Approved (GA) HMO risk to pay,

f. Other comments must explain what actions were taken to prevent the member from continuing to be billed.

Note: If check date, capitated date, denied date or write off date is more than 30 days from the date of the PDC notice, the IPA must contact the provider to resolve the issue and enter a current date that the provider was contacted.

4. If an IPA responds to the PDC via the web-based process with an incorrect response, the IPA can submit a corrected response by following the procedure below;

   a. Open the claim in question on the web.

   b. Make a screen print from the detail page that shows the status.

   c. Write directly on the screen print the corrected status.

   d. Explain the reason for the change in status.

   e. Print your name and the name of the IPA and the IPA's site number.

   f. Email to***:*** hmoiinquiryrequests@bcbsil.com***.***

   Note: All changes must be submitted within 24 hours from the IPA's original response to the PDC.

5. IPAs requesting a copy of the claim(s) can do so via e-mail no later than five (5*) calendar* days before the PDC response due date. On the subject line of the e-mail, include the HMO name and the IPA site number and in the body of the e-mail, list the IPA fax number. Using the HIPAA compliant encryption (PHI space and subject), IPAs can send requests to the following e-mail address for HMO Illinois Commercial (group #s that begin with an H), Blue Advantage HMO (group #s that begin with a B), and Blue Precision Small Employer Group (group #s that begin with R): HMOIclaimrequests@bcbsil.com

   Using the HIPAA compliant encryption (PHI space and subject), IPAs can send requests to the following e-mail address for HMO Exchange Blue Precision Individual Members (group #'s that begin with I), and BlueCare Direct Members (group #s that begin with I): HMOIclaimrequests@bcbsil.com

6. If an invalid response is received, claims are paid by the HMO at full charges and the payment is deducted from the IPA's capitation, the appropriate internal areas are notified and a monthly PDC report is posted on the BCBSIL IPA Access Portal for the IPAs.

7. All capitation deductions will be listed on the monthly capitation summary report.

8. If the provider refunds HMO as a result of a duplicate payment, HMO will automatically refund to the IPA via capitation check the amount the provider refunded to HMO.

9. If the IPAs feel deductions are inappropriate, they have the right to challenge the PDC deductions. The IPA can challenge the deduction as per outlined below.

Capitation Deduction Process:

1. The Health Care Management Business Systems Analyst will run the PDC report by IPA on the tenth of each month to identify all claims paid as a PDC from the previous month.

2. The Financial Analyst will generate a report and process adjustments on the next capitation check.

3. The capitation check summary will show the total PDC deduction for all members for all claims paid in the previous period. The PDC report detailing the monthly capitation deductions by the member will be posted to the BCBSIL IPA Access Portal by the 10th of the month.

IPA Challenge:

1. The IPA may challenge the PDC deduction by submitting proof that a valid response was provided to the PDC notice within the allotted 10 calendar days. The challenge should be submitted in accordance with the process outlined below within 60 calendar days of the capitation deduction.

2. All PDC challenges must be submitted electronically. There is an Excel template that must be used to submit the challenge located on the BCBSIL IPA Access Portal at https://bcbsilezaccess.com/ipa_portal/default.aspx > Provider Network Management > HMO > HMO Report Templates

   The challenge form should be emailed to hmoillinoispdcappeals@bcbsil.com within 60 calendar days of the deduction(s). If the IPA does not have access to the portal, they can contact the HMO Provider Network Consultant to obtain a copy of the PDC challenge form. The first worksheet is the template challenge form.

   a. Make a copy of the template worksheet and create a new worksheet within the Excel spreadsheet and rename the new worksheet with the DCN number and the member's last name. Example: 200987654321-Smith.

   b. Create a worksheet, within the Excel spreadsheet, for each PDC that is being challenged. Only one Excel file should be submitted for each month's challenges, but the Excel file will have multiple worksheets if challenging more than one PDC deduction.

      Note: If there is additional documentation that supports the challenge, copy it into a WORD or PDF document and submit with the challenge.

   c. Once complete, send the Excel spreadsheet, along with any supporting documentation to: hmoillinoispdcappeals@bcbsil.com

   d. To expedite the delivery, the IPA can send an e-mail to HMO. IPA staff submitting the PDC challenge can send an e-mail to the designated HMO Provider Network Consultant requesting a secure e-mail be sent which will assist them in setting up access.

3. The Service Center will review the challenge and provide a written response to the IPA within 30 calendar days of receipt of the challenge. The challenge file will be e-mailed securely back to the sender copying the HMO Provider Network Consultant.

    a. If the Service Center concurs with the IPA and the IPA has submitted proof of payment, the Service Center will request a refund from the provider. The IPA will be reimbursed upon receipt of the refund. If the deduction was made due to an HMO processing error, the IPA will receive a refund prior to the provider reimbursing the HMO.

    b. If the IPA originally responded to the PDC stating the claim was non-group approved, and the HMO made the deduction, further review will be completed. The claim will also be reviewed for Life Threatening Emergency (LTE) guidelines. If the guidelines are met, the HMO will reprocess the claim and reimburse the IPA. If the claim does not meet LTE criteria, the HMO will reimburse the IPA reprocess the claim requesting a refund from the provider and send a revised Explanation of Benefits to the member.

    c. If the Service Center does not concur with the challenge, the Service Center will provide a written explanation to the IPA within 30 calendar days

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Line of Business and/or Area	Control Requirements
HMO	Controls are detailed in the BCBSIL Documentation Inquiry Tool / Knowledge Article

V. AUTHORITY AND RESPONSIBILITY

HMO Network
HMO Operations
BCBSIL Service Centers

VI. IMPACTED BUSINESS AREAS

Impacted areas include**:**

- HMO Commercial and HMO Exchange Service Centers
- HMO Network
- HMO Customer Assistance Unit
- Provider Network Financial Management

VII. IMPACTED EXTERNAL ENTITIES

HMO IPAs

VIII. PROCEDURE REVIEWERS

Person Responsible for Review	Title	Date of Review
Jessica Whaley	HMO Provider Network Consultant	10/08/2024

IX. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
Revised Procedure header, added Section II Policies Implemented by Procedure, deleted references to Blue Focus Care, deleted related documents	10/08/2024

X. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
Provider Performance	Geoff Guiton	Executive Director, Provider Performance	10/18/2024
BCBSIL P&P Committee			10/24/2024

XI. PROCEDURE ATTACHMENTS / ADDITIONAL INFORMATION

HMO ILLINOIS/BLUE ADVANTAGE HMO
A Blue Cross HMO

HMO Past Due Claims Appeal Form

(Form must be filled out completely to be considered for appeal)

Date: _____ IPA#: _____

Group #: _____ ID #: _____

Name: _____

Service Date: _____ Billed _____

Provider Name: _____ Claim #: _____

Did you receive the PDC notice? ☐
(Must be Yes or No)

Did you respond to the PDC notice? ☐

(Section below must be completed to receive cap reimbursement if appeal is approved)

☐ Provider was capitated for these services. Provider was called and instructed not to bill the member again. Capitated on: Provider was called on:

☐ Stale dated claim. Provider was called on & instructed to write off charges.

☐ Claim was paid: Date paid: Check #:

☐ Not Group Approved

☐ Other :

Reply Section - To be completed by the HMO

Appeal Approved: Appeal Denied:

Explanation:

Completed by: _____ Date Completed: _____