



**BLUE CROSS AND BLUE SHIELD OF ILLINOIS
PROCEDURE**

DEPARTMENT: Network Provider Performance	POLICY NUMBER: Administrative 42A	ORIGINAL EFFECTIVE DATE: 09/01/1999
POLICY TITLE: Past Due Claim (PDC) Process		EFFECTIVE DATE: 11/01/2022
		LAST REVISION DATE: 11/01/2021
EXECUTIVE OWNER: DSVP, IL Health Care Delivery	BUSINESS OWNER: Manager, Provider Performance	LAST REVIEW DATE: 11/01/2022

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 Exchange	x
PPO Commercial	
PPO Exchange	

I. 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), Blue Precision Small Employer Group (group #s that begin with R) and Blue Care Direct (group #s that begin with an A): 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), BlueCare Direct Members (group #s that begin with I) and Blue FocusCare 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 hmoillinoispdcapeals@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: hmoillinoispdcapeals@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

II. CONTROLS/MONITORING

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

- 2. Membership Status:
 - The member must have been assigned to a valid IPA at the time services were rendered.
- 3. 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 days previous to member’s bill/statement or,
 - The bill/statement date is more than 45 days old from date of service or,
 - The claim is currently in collection status.
- 4. Statement Status:
 - The date of service should be more than 45 days and,
 - The claim in question should have a statement date that is less than 30 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 Documentation Inquiry Tool / Knowledge Article

III. AUTHORITY AND RESPONSIBILITY

HMO Network
 HMO Operations
 BCBSIL Service Centers

IV. RELATED DOCUMENTS

Administrative 42 – Past Due Claim Process

V. IMPACTED BUSINESS AREAS

Impacted areas include:

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

VI. IMPACTED EXTERNAL ENTITIES

HMO IPAs

VII. PROCEDURE REVIEWERS

Person Responsible for Review	Title	Date of Review
HMO Commercial and Exchange Service Centers	Bonnie Kovanda, Supervisor Customer Service	10/6/2021
HMO Commercial and Exchange Service Centers	Bonnie Kovanda, Supervisor Customer Service	09/7/2022

VIII. PROCEDURE REVISION HISTORY

Description of Changes	Revision Date
Transferred P&P to new P&P template	09/29/2021

IX. PROCEDURE APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
BCBSIL P&P Committee			10/28/2021
BCBSIL P&P Committee			10/27/2022

X. 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: _____

Blue Cross/Blue Shield of Illinois
A Member of the Blue Cross and Blue Shield Association, An Association of Independent Blue Cross and Blue Shield Plans