BLUE CROSS AND BLUE SHIELD OF ILLINOIS
POLICY

DEPARTMENT: Network Provider Performance	
POLICY NUMBER: Administrative 67	**POLICY TITLE:** HMO Financial Risk Claims
EXECUTIVE OWNER: Executive Director, Provider Performance	**BUSINESS OWNER:** Manager, Provider Performance
ORIGINAL EFFECTIVE DATE (IF KNOWN): 06/01/2002	**COMMITTEE APPROVAL DATE:** 11/14/2024

I. SCOPE

This Policy applies to 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 in processing claims that are the financial risk of BCBSIL.
- To improve provider and member satisfaction by promptly paying claims.
- To improve member satisfaction by reducing billing and collection notices.
- To allow the IPA the ability to assume financial risk.

III. POLICY

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

IV. CONTROLS/MONITORING

Line of Business and/or Area	Control Requirements
HMO	Controls included in Policy and Procedure

V. RELATED DOCUMENTS

Automatic Approval Process – Policy 53 , 53A
HMO Financial Risk Claims – Procedure 67A

VI. IMPACTED BUSINESS AREAS

HMO Customer Assistance Unit (CAU)
HMO Financial Analysis
HMO Network
HMO Operations
HMO Service Centers including claims, eligibility etc.

VII. POLICY REVIEWERS

Person Responsible for Review	Title	Date of Review
Rachel Schmitt, Jessica Whaley	HMO Provider Network Consultants	10/30/2024

VIII. POLICY REVISION HISTORY

Description of Changes	Revision Date
No content changes	10/30/2024

IX. POLICY APPROVALS

Company, Division, Department and/or Committee	By: Name	Title	Approval date
BCBSIL P&P			11/14/2024
Provider Performance	Geoff Guiton	Executive Director, Provider Performance	11/14/2024

BLUE CROSS AND BLUE SHIELD OF ILLINOIS
PROCEDURE

DEPARTMENT: Network Provider Performance	
PROCEDURE NUMBER: Administrative 67A	**PROCEDURE TITLE:** HMO Financial Risk Claims
EXECUTIVE OWNER: Executive Director, Provider Performance	**BUSINESS OWNER:** Manager, Provider Performance
ORIGINAL EFFECTIVE DATE (IF KNOWN): 06/01/2002	**COMMITTEE APPROVAL DATE:** 11/14/2024

I. SCOPE

This Procedure applies to 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
Automatic Approval Process	Admin 53
HMO Financial Risk Claims	Admin 67

III. PROCEDURE

1. The claim will be submitted either electronically or on paper to BCBSIL for processing.
2. Once the claim is received it will be reviewed to determine if it was submitted with the approval status on the claim or if BCBSIL needs to reach out to the IPA to obtain approval status.

    - If a paper claim is submitted with an approval stamp from the IPA, the claim will go through the normal claims processing channels.
    - If the claim (electronic or paper) was submitted on a UB-04 and the claim has a value of 1 (Physician Referral) or 3 (HMO Referral) in the Source of Admission field (15) and “GAP” in the Treatment Authorization field (63), the BCBSIL claims processing system will read the online provider file to verify if the facility and IPA have an Expedited Approval Agreement (GAP) Agreement in place. The claim will be processed accordingly if all criteria are met.
    - If it is determined that the facility and IPA do not have an Expedited Approval Agreement (GAP) agreement in place, the claim will be pended and be sent to the IPA via the internet 095 report to obtain approval status.

NOTE: BCBSIL will not automatically provide a copy of the claim, for which we are seeking approval status, to the IPAs. The IPAs can contact BCBSIL to request a copy of the claim if they need the claim to determine approval status.

3. The IPA is required to respond within 10 calendar days to the 095 Report by checking the appropriate box for each claim listed. All responses must be received prior to 7:59 p.m. on the 10th calendar day.

4. Guidelines for determining group approval status on the 095 Report:

    a. GA – Group Approved
    Claim is group approved, services were rendered by or referred by a Primary Care Physician (PCP) or Participating Specialist Provider (PSP) affiliated with the IPA.

    b. NGA – Not Group Approved
    Claim is not group approved, member was not treated by or referred by a PCP or PSP affiliated with the IPA.

    c. MGR – Med Group Risk

    Claim is group approved and is the financial risk of BCBSIL, but the IPA has made the determination to assume the responsibility to pay the provider, then the following rules apply:

        1. The IPA must pay according to the rules of Prompt Pay legislation.
        2. No units will be charged on the Utilization Management (UM) Fund.
        3. The claim will not be considered in the reinsurance calculations.
        4. If a member calls BCBSIL after 45 days from the response to the 095 Report stating the claim remains unpaid, BCBSIL will contact the provider. If the bill is unpaid, BCBSIL will pay the claim, units will be charged, and the IPA forfeits the right to challenge the UM Fund.

    d. If an IPA risk claim appears on the 095 Report, check GA or NGA and in the comment, field indicate the claim is IPA risk.
    e. Partial Group Approved – PGA – If the IPA is notified of an in-patient admission, the IPA indicates ‘PGA ‘from the point of notification of the in-area in-patient admission.

5. If the IPA fails to respond to the 095 report by 7:59 pm on the 10***th*** calendar day, the claims will default to a status of Group Approved and BCBSIL will process the outstanding claims.
    a. Appropriate units will be charged against the IPA’s UM Fund.
    b. Challenges to the UM Fund on claims that the IPA failed to respond to will be denied.
    c. All claims related to that date of service that are the IPA’s financial risk will also default to Group approved status and the IPA will be required to pay all related services.

6. If the IPA submits an incorrect approval status (whether via an 095 response or a stamped paper claim) and changes the status from group-approved to non-group-approved, the IPA must send their request to change the status within five calendar days

of the original submission. See additional information in the BCBSIL Provider Manual HMO Claims Processing Section.

7. If the IPA fails to submit a status change request from group-approved to non-group approved within five calendar days, the claim will remain as Group Approved;

    a. All IPA financial risk claims related to that date of service will default to Group approved and the IPA will be required to pay all related services.
    b. Global approval status will be applied to IPA financial risk claims for any additional services incurred and/related to the original service approved (in error). The IPA will be required to pay all related services.

IV. CONTROLS/MONITORING

Line of Business and/or Area	Control Requirements
HMO	Controls are included on Policy and Procedure

V. AUTHORITY AND RESPONSIBILITY

HMO Network and HMO Service Centers are responsible for updating, maintaining and implementing the guidelines to identify HMO risk claims. HMO IPAs are responsible to adhere to the guidelines to ensure appropriate claim adjudication.

VI. RELATED DOCUMENTS

Automatic Approval Process- Procedure 53A
HMO Financial Risk Claims – Procedure 67A

VII. IMPACTED BUSINESS AREAS

HMO Customer Assistance Unit (CAU)
HMO Financial Analysis
HMO Network
HMO Operations
HMO Service Centers including claims, eligibility etc.

VIII. IMPACTED EXTERNAL ENTITIES

HMO Medical Groups
Providers

IX. PROCEDURE REVIEWERS

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