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Confidential and Proprietary

General Regulations

Contracting Provider Groups or Individual Providers (“Contracting Provider”) shall submit all claims for consideration for payment for Covered Services performed for Blue Cross and Blue Shield (“BCBS”) members utilizing claim forms as set forth in the Billing and Reimbursement section of this manual. In addition to the instructions in this section and other sections of the manual, Contracting Provider shall adhere to the following policies with respect to filing claims for Covered Services to BCBS members:

1. A Contracting Provider performing covered services for a BCBS member shall be fully and completely responsible for all statements made on any claim form submitted to Blue Cross and Blue Shield of Illinois (“BCBSIL”) by or on behalf of the Contracting Provider. A Contracting Provider is responsible for the actions of staff members or agents.
2. All Covered Services provided for and billed for BCBS members by Contracting Provider shall be performed personally by the Contracting Provider or under that provider’s direct and personal supervision and in that provider’s presence, except as otherwise authorized and communicated by BCBSIL. Direct personal supervision requires that a Contracting Provider be in the immediate vicinity to perform or to manage the procedure personally, if necessary.
3. A Contracting Provider must file complete and accurate claims with BCBSIL. In the event any Contracting Provider has received, either from BCBSIL or from the member, an amount in excess of the amount determined by BCBSIL to be payable with respect to services performed, such excess amount shall be returned promptly to BCBSIL or to the member, as the case may be. In the event such overpayments are not voluntarily returned, BCBSIL will be permitted to deduct overpayments (whether discovered by the Contracting Provider or BCBSIL) from future BCBSIL payments.
4. BCBSIL considers abusive or fraudulent billing to include, but not be limited to, the following:
 - a) Misrepresentation of the services provided to receive payment for a non-covered service;
 - b) Billing in a manner which results in reimbursement greater than what would have been received if the claim were properly filed; and/or
 - c) Billing for services which were not rendered.

If BCBSIL determines, in its sole discretion, that a provider has engaged in abusive or fraudulent billing practices, BCBSIL may take further actions up to and including termination of the provider from the PPO Network.

5. To the greatest extent possible, the Contracting Provider shall report services in terms of the procedure codes listed in the most recent version of Current Procedural Terminology (CPT®) coding manuals and ICD-10 reference books. In unusual cases, a description of the service, a copy of the hospital/medical records or other appropriate documentation should be submitted.
6. A Contracting Provider shall not bill or collect from the member, or BCBSIL, charges itemized and distinguished from the professional services provided. Such charges include, but are not limited to, malpractice surcharges, overhead fees or facility fees, concierge fees or fees for completing claim forms or submitting additional information to BCBSIL.
7. The determination as to whether any Covered Service meets accepted standards of practice in the community shall be made by BCBSIL in consultation with Contracting Provider engaged in active clinical practice. Fees for Covered Services deemed not to meet accepted standards of practice shall not be collected from the member or BCBSIL.

8. **Medically Necessary or Medical Necessity** shall mean health care services that a Contracting Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, provider specialty society recommendations and the views of Contracting Provider practicing in relevant clinical areas and any other relevant factors.

Note: The definition above is used in most instances. However, in the event an applicable law, regulation or member's benefit plan contains a different definition, that definition shall govern.

9. BCBSIL has the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary. A Contracting Provider shall render Covered Services as necessary and appropriate for the patient's condition and not mainly for the convenience of the member or Contracting Provider. In the case of diagnostic testing, the tests should be essential to, and be used in, the diagnosis and/or management of the patient's condition. Services should be provided in the most cost-effective manner and in the least costly setting required for the appropriate treatment of the member. Fees for Covered Services deemed not medically necessary shall not be collected from the member, unless the member requests the service(s), the Contracting Provider informs the member of his or her financial liability and the member chooses to receive the service(s). The Contracting Provider must document such notification to the member in the Contracting Provider's records and the member's written consent to accept financial responsibility for such services.
10. A Contracting Provider may, at all times, bill a BCBS member for non-covered services. The determination as to whether any services performed by a Contracting Provider for a BCBS member are covered by a Blue Cross and Blue Shield Agreement or benefit plan, and the amount of payment for such services, shall be made by BCBSIL.
11. The Contracting Provider will maintain adequate medical and administrative records consistent with the standards of major organizations conducting accreditation and will permit the Plan or its agent or representative to review such medical records and administrative records regarding Covered Persons. The Contracting Provider will furnish to the Plan, or its agent or representative, necessary quality improvement data and will permit the Plan or its agent or representative to perform site visits to inspect and review such records and inspect the Contracting Provider's office facility and equipment during normal business hours as mutually agreed upon in advance for the purpose of the Plan's performing utilization management and quality improvement activities. Contracting Provider shall permit Plan or its Designees, upon reasonable notice and during normal business hours, to have, without charge, access to and the right to examine, audit, excerpt and transcribe any books, documents, papers and records relating to Covered Person's medical and billing information within the possession of the Contracting Provider and to inspect the Contracting Provider's operations, which involve transactions relating to Covered Persons and as may be reasonably required by the Plan in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, Medical Necessity, appropriateness of care, and accuracy of billing and payment. The Contracting Provider shall make such records available to state and federal authorities, as well as any accrediting bodies which the Plan is accredited by or from which it is seeking accreditation, involved in assessing quality of care, fraud, abusive billing practices, or investigating Covered Person's grievances or complaints. The Contracting Provider agrees to provide the Plan or its Designees with appropriate working space. Upon reasonable request, photocopies of such records shall be provided to Plan, Payer or their Designee at no charge.

12. A Contracting Provider shall not refer a BCBS member to a provider that does not participate in BCBSIL networks absent a written waiver signed by the member or the approval of BCBSIL. Referral to any other provider/facility, regardless of whether that provider/facility is a Contracting Provider, with which the Contracting Provider has a business interest, must be acknowledged to the patient in writing at the time of the referral.
13. A Contracting Provider is prohibited from paying or receiving a fee, rebate or any other consideration in return for referring a BCBS member to another provider, or in return for furnishing services to a member referred to him or her.
14. Contracting Provider will ensure that Covered Services reported on claim forms are supported by documentation in the medical record and adhere to the general principles of medical record documentation, including but not limited to the following, if applicable to the specific setting/encounter:
 - Medical records should be complete and legible;
 - Documentation of each patient encounter should include:
 - Reason for the encounter and relevant history;
 - Physical examination findings and prior diagnostic test results;
 - Assessment, clinical impression and diagnosis;
 - Plan for care; and
 - Date and legible identity of observer.
 - If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
15. Every BCBS subscriber will be supplied with an appropriate identification card and the Contracting Provider shall be responsible for verifying the identity of the BCBS subscriber (e.g., government issued photo identification or other proof of identity). The identity of the BCBS subscriber must be verified each and every time services are provided.
16. Prior Authorization of benefits for services may be required in accordance with a member's contract with BCBSIL. Services that do not receive prior authorization could result in claims being paid at a lesser benefit level or in claims payment denial and members must be held harmless. If it is determined that a favorable prior authorization or predetermination of benefits decision was based on inaccurate or misleading information submitted by the Contracting Provider or the member, BCBSIL may refuse to pay the claim or seek recovery of paid claims. Charges for services which are not paid as the result of submission of false or inaccurate information by the Contracting Provider shall not be collected from the member.
17. A Contracting Provider is expected to complete all necessary information on the claim forms which will facilitate Coordination of Benefits with other third party payers by BCBSIL.
18. Contracting Providers may not bill BCBSIL 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 rendering provider, spouse or domestic partner; (iv) children and grandchildren (biological, adopted or other legally placed children) of the rendering provider, spouse or domestic partner; and, (v) siblings (including biological, adopted, step, half or other legally placed children) of the rendering provider, spouse or domestic partner. BCBSIL will not process any claims for services, nor make payment for any claims for services, rendered by a Contracting Provider to him or herself, or to his or her Immediate Family Members. In the event that BCBSIL determines that a benefit was paid in error, BCBSIL has the right to request and receive a refund of the payment from the Contracting Provider.

BCBSIL does not expect to receive claims for these services and will not make payment on claims submitted for services rendered by or for immediate family. Should it be determined that a benefit has been paid in error, BCBSIL will request a refund of the original payment.

19. A Contracting Provider should be knowledgeable of BCBSIL's Medical Policies. Medical Policies serve as one of the sets of guidelines for benefit coverage decisions. Member benefit plans vary in coverage and some plans may not provide benefit coverage for certain services discussed in the medical policies. Benefit coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations and to applicable state and/or federal law. For additional information and to view all active, pending and draft medical policies please view BCBSIL's [Medical Policies](#). Medical Policies are located on the Provider website under Standards and Requirements. In some cases, medical policies/guidelines used by Utilization Management vendors may apply, such as some services for which prior authorization may be required.
20. Checking benefits and eligibility, either online or via phone, is not a guarantee of benefits or payment. Benefits will be determined once a claim is received by BCBSIL and will be based upon, among other things, the member's eligibility, benefits, limitations and exclusions, terms of the member's certificate of coverage and medical policy in effect on the date services are rendered. BCBSIL reserves the right to request refunds for a variety of reasons including, but not limited to, those stated in paragraph #3 above.
21. In accordance with the terms of the Contracting Provider Agreements, Contracting Providers must maintain a current physical address (which is not a P.O. Box) and phone number at which the Contracting Provider can be reached. Such information may be placed on BCBSIL's Contracting Provider directory. The Contracting Provider must provide thirty (30) days prior written notice of any change in address, phone number and/or change in employment status, such as retirement. Additionally, BCBSIL reserves the right to audit such information to verify its accuracy and the Contracting Provider shall be required to provide and/or confirm such information as requested by BCBSIL. BCBSIL reserves the right to delete any Contracting Provider from its directory for failure to provide and/or confirm the office address and phone number of the Provider. Further, BCBSIL reserves the right to terminate a Contracting Provider's Agreement if the Contracting Provider fails to provide and/or confirm such information.
22. Contracting Provider authorizes Plan to obtain the clinical laboratory results for tests performed on Covered Persons as well as for tests performed on Plan's enrollees entitled to receive benefits under any health care benefit plan offered and/or administered by the Plan or its subsidiaries or another Blue Cross and Blue Shield Plan or their subsidiaries. Participating Provider shall inform Members that the Plan may receive the clinical laboratory results and shall include this, or a similar statement, in any informed consent forms signed by the Member.
23. 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, the Centers for Medicare & Medicaid Services (CMS), CPT, Change Healthcare and Cotiviti coding process edits and rules.

Third-Party Billing Requirements and Member Waivers

A Contracting Provider contracted with BCBSIL is required to submit to BCBSIL all claims for Covered Services rendered to BCBSIL members ("Members"), whether or not the costs for such claims may be the responsibility of a third-party (e.g. an auto carrier when a person is injured in an auto accident). When a Contracting Provider submits a claim to BCBSIL seeking payment under the terms of that provider's Contracting Provider agreement with BCBSIL, all terms of the Contracting Provider agreement are applicable, and the Contracting Provider must accept BCBSIL reimbursement as full and final payment for services rendered, excluding any applicable Member financial responsibility including, but not limited to, copayments and coinsurance. If it is later determined that another person or entity is liable to the Member, the Contracting Provider cannot refund the payment to BCBSIL and seek full billed charges from the liable person or entity.

However, if a Member voluntarily chooses to waive that member's benefits and agrees to provide a signed, written document to a contracted Contracting Provider, waiving that member's insurance benefits with BCBSIL for a particular claim(s) ("Waiver"), and allowing the Contracting Provider to seek payment only from the Member or one or more third-parties (collectively, "Third-Party"), BCBSIL will honor the Member's decision to waive his or her insurance benefits and the Contracting Provider may bill the Member or a Third-Party for Covered Services rendered. The Waiver must specifically state that the Member is: (i) voluntarily and knowingly waiving his or her health benefits with BCBSIL, and (ii) aware that the Contracting Provider is intending to seek payment from the Member or a Third-Party, which may include a recovery from the Member's potential or actual settlement dollars or award from such Third-Party, regardless of whether the Third-Party denies or admits liability for the Member's injury or illness, and (iii) aware that the Contracting Provider will seek that provider's full billed charges (or, if applicable, some other specifically identified amount) from the Member or a Third-Party, instead of the Contracting Provider's discounted rate with BCBSIL, and (iv) the Member may rescind the Waiver at any time, however, such retraction of the Waiver may not be retroactive, and (v) the Member understands that BCBSIL will have no responsibility for payment of any health care services covered by the Waiver which, but for the Waiver, would have been considered eligible for benefits and/or payable by BCBSIL under the Member's health benefit plan, even if no Third-Party is determined to be liable for the payment.

Nothing in this section changes, waives or amends any BCBSIL policies relating to claims, claims submission to BCBSIL (including, but not limited to, format and timely filing requirements) or subrogation. This policy does not affect in any way coordination of benefits where the BCBSIL Member has health benefit coverage under more than one policy or plan. All BCBSIL policies remain in force and effect.

Third-Party Premium Payments

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with Federal guidance, BCBSIL will accept third-party payment for premium directly from the following entities:

(1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations or urban Indian organizations; and (3) state and federal Government programs.

BCBSIL may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the Covered Persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSIL directly for any or all of an enrollee's premium.

Effective May 1, 2010, the following provisions apply to all Contracting Providers.

Disputes

- I. Any disputes arising out of the terms of the Provider Agreement (the "Agreement") shall be governed by and subject to the laws of the State of Illinois.
- II. In order to avoid the cost and time consuming nature of litigation, any dispute between Plan and Contracting Provider arising out of, relating to, involving the interpretation of or in any other way pertaining to the Agreement, or any prior Agreement between Plan and Contracting Provider that relates to Provider's role as a Participating Provider for the Provider Networks indicated in the Agreement for Covered Persons, or any Laws relating thereto, shall be resolved using alternative dispute resolution mechanisms instead of litigation. Plan and Contracting Provider agree and acknowledge that it is their mutual intention that this provision be construed broadly so as to provide for individual mediation and/or arbitration of all disputes arising out of their relationship, including claims not yet filed that predate the Agreement, as third party payer and provider. The Parties further agree that resolution of any dispute pursuant to the Agreement shall be in accordance with the procedures detailed below:

A. Initial Resolution by Meeting or Mediation of Dispute

1. Plan or Contracting Provider, as the case may be, shall give written notice to the other of the existence of a dispute (the "Initial Notice").
2. Plan and Contracting Provider shall schedule a meeting not later than thirty (30) calendar days after delivery of the Initial Notice in order to attempt to resolve the dispute unless both Parties agree in writing to proceed directly to mediation. If the dispute is not resolved at any meetings held, the Parties shall submit the dispute to a mutually agreed upon mediator. The mediation process shall be subject to the following conditions
 - a) The Parties agree to participate in the mediation confidentially and in good faith;
 - b) The Parties agree to have present at the mediation one or more individuals in the Parties' employ with decision-making authority regarding the matters in dispute. Either Party may, at that Party's option, be represented by counsel;
 - c) The mediation will be held within sixty (60) days of the mediator's acceptance of the matter unless the Parties agree on a later date. The mediation will be held in Chicago, Illinois;
 - d) The Parties shall each bear their own costs and shall each pay one-half of the mediator's fees and costs, unless the mediator determines that one Party did not participate in the mediation in good faith, in which case that Party shall pay all of the mediator's fees and costs;
 - e) The Parties agree that the obligation to mediate (but not the obligation to arbitrate) is not applicable to any dispute that was pending in any court on the effective date of the Agreement, or that had been submitted to binding arbitration on or before the effective date of the Agreement.

B. Binding Arbitration

In the event mediation is not successful in resolving the dispute, either Plan or Contracting Provider, on Contracting Provider's own behalf and not as a representative of a purported class, may submit the dispute to confidential, final and binding arbitration under the commercial rules and regulations of Arbitration of the American Arbitration Association, subject to the following:

1. The arbitration shall be conducted by a single arbitrator selected by the Parties from a list furnished by the American Arbitration Association. If the Parties are unable to agree on an arbitrator from the list, the arbitrator shall be appointed by the American Arbitration Association.
2. The arbitrator shall be required to render a written decision resolving all disputes, designating one Party as the "prevailing party."
3. Except in the case of fraud, no arbitration decision may require any adjustment in compensation or payments respecting any dispute involving services rendered more than twenty-four (24) months prior to receipt of the Initial Notice.
4. Neither Party shall be entitled to an award of lawyers', consultants', or witness fees, it being the intention of the Parties that each side shall bear its own lawyers', consultants' and witness fees. The costs of arbitration, including the arbitrator's fee and any reporting or other costs, but excluding lawyers', consultants' and witness fees, shall be borne by the non-prevailing Party unless the arbitrator determines as part of the award that such allocation is inequitable under the totality of the circumstances. In the event that the dispute in arbitration concerns the appropriateness of Plan's adjudications of Claims, the Party challenging the adjudications shall have the initial burden of proving that there is a reasonable probability that the disputed Claims adjudications were incorrect adversely to that Party. When the other Party reasonably determines that it is required in its defense, or is required by the discovery process or otherwise by Law, to research the basis for the adjudications of challenged Claims for which such reasonable probability has not been proven, the other Party shall be awarded the administrative cost for such research for each such Claim that is found in the arbitration proceeding, after such research, not to have been adjudicated incorrectly adversely to the challenging Party.
5. The arbitration hearing will be held in Chicago, Illinois;
6. The arbitrator may award declaratory or injunctive relief only in favor of the Party seeking relief and only to the extent necessary to provide relief warranted by that Party's individual claim. Contracting Provider and Plan agree that each may bring claims against the other only in its individual capacity, and not as a plaintiff or class member in any purported class or representative proceeding. Further, unless both Contracting Provider and Plan agree otherwise, the arbitrator may not consolidate Contracting Provider's claims with the claims of any other Provider or third-party, and may not otherwise preside over any form of a representative or class proceeding; and
7. Facility acknowledges that this arbitration provision precludes Contracting Provider from filing an action at Law or in equity and from having any dispute covered by the Agreement resolved by a judge or a jury. Contracting Provider further acknowledges that this arbitration provision precludes Contracting Provider from participating in a class action filed by any other Contracting Provider or any other plaintiff claiming to represent Contracting Provider or Contracting Provider's interest. Contracting Provider agrees to opt-out of any class action filed against Plan that raises claims covered by the Agreement to arbitrate, including, but not limited to, class actions that are currently pending.

C. Exceptions. The provisions of this Article shall not be applicable to the following:

1. Any legal proceeding brought by a third-party against Plan or Contracting Provider (a “Defendant”), as well as any cross-claim or third-party claim by such Defendant against Plan or Contracting Provider.
2. Termination of the Agreement pursuant to a termination without cause.
3. Immediate termination of the Agreement if based on external data relating to loss of licensure, status, certification, maintenance of insurance, breach of warranty, inducement, or Plan’s judgment relating to cases involving standard of care or patient safety. However, a wrongful termination claim may be brought to recover the contractual rates under the Agreement.

Confidential and Proprietary

Timely Filing

BCBSIL Facility Providers

Claims must be filed with BCBSIL on or before December 31 of the calendar year **following** the year in which the services were rendered. Services furnished in the last quarter of the year (October, November and December) are considered to be furnished in the following year. For example, a claim with a service date between Oct. 1, 2018, and Sept. 30, 2019, must be filed before Dec. 31, 2020. Claims not filed within the above time frames will not be eligible for payment.

Professional PPO, Blue Choice PPOSM and Blue HPNSM Providers

The contracted provider agrees to bill the Plan in a timely manner and in a method acceptable to the Plan for payment prior to charging the covered person for any deductible or coinsurance amount. The Plan agrees to pay the contracted provider, directly and on a timely basis, for covered services rendered to a covered person as described in the covered person's applicable health care benefit contract. In no event will the Plan, its designee, a covered person, a covered person's representative, a payer or any other person or entity be obligated to pay all or any portion of any claim for covered services that is not received by the Plan within the one hundred and eighty (180) day period following:

- The date of discharge or transfer for inpatient Health Services;
- The date of service for all other health services that are not inpatient; or
- 180 days after the date of the Contracting Provider's receipt of the explanation of benefits from primary payer when Plan is the secondary payer. The Plan will consider any request for a reasonable extension of the 180 day time period for filing claims, on a case by case basis, if the contracted provider provides notice to Plan along with appropriate evidence of circumstances beyond the reasonable control of the contracted provider that resulted in the delayed submission of the claim. The Plan reserves the right, in its sole discretion, to determine whether a reasonable extension of the timely filing requirement should be granted.

Note: There are some employer groups that have different and specific time frames for filing claims. This information may be obtained when calling for eligibility and benefits.

Coordination of Benefits (COB)

The BCBS Coordination of Benefits (COB) provisions are based on the National Association of Insurance Commissioners (NAIC) Model and the applicable Department of Insurance rules regarding Group Coordination of Benefits. The COB provision applies when a BCBS policy holder/subscriber or covered dependent has health care coverage under more than one plan.

Note: For self-insured plans, the COB rules may be different.

All payments made by BCBSIL are subject to the COB provisions of the applicable benefit plan. When a covered person has other coverage under another group plan or any deductible, copayment or coinsurance balance, the total amount payable by the plan and the secondary carrier cannot exceed the maximum allowance or the contracted provider's fee, whichever is less.

Order of Benefit Determination Rules

If an insurance plan does not contain a provision for coordination of benefits, then that plan will have primary responsibility for payment of benefits.

If an insurance plan does contain a provision for coordination of benefits, the rules for establishing the order of benefit determination are:

1. The coverage under which the patient is the eligible person (rather than a dependent) is primary. The other coverage is secondary and only considers any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision, and as a result both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
 - a) However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefit of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as dependent of the parent without custody.
 - b) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers the child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.
 - c) Notwithstanding the items above, if there is a court decree that would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.
3. If none of the rules above apply, then the coverage that has been in effect the longest is primary.

COB Investigation

If other party liability indications are present on the claim, or on the COB History File Index, that another carrier is primary, BCBSIL will investigate for other carrier information. Contracted providers will receive an informational message on the Electronic Remittance Advice (ERA) or Provider Claim Summary (PCS) that the other carrier EOB is needed to continue processing the claim. Members will also receive a similar message on the Explanation of Benefits (EOB), as well as receiving a Customer Service Questionnaire (CSQ) letter requesting other carrier information.

BCBSIL will pay as primary, assuming our subscriber/policy holder is primary on their own policy, unless other party liability is indicated on the claim or on the COB History File Index.

Appeal Process (External Review)

Any individual physician or physician group may submit a Billing Dispute for an External Review when the physician or physician group has exhausted all BCBSIL internal appeals for resolution of billing disputes or, when the amount in dispute exceeds \$500. For any billing disputes that a physician or physician group submits for external review, the physician or physician group submitting the dispute shall pay to BCBSIL a filing fee equal to \$50 for amounts in dispute between \$500 and \$1,000. For amounts in dispute greater than \$1,000, the filing fee shall be equal to \$50 plus five percent of the amount by which the amount in dispute exceeds \$1,000, but in no event shall the fee be greater than 50 percent of the cost of the review.

Claim Filing and Claim Submission**Electronic Claims**

Electronic submission of professional and institutional claims (ANSI 837 transactions) helps optimize the flow of information between providers and health plans. Claims may be submitted via your practice management system, Availity®, Experian Health or your preferred vendor portal. Refer to the Claims and Eligibility/Electronic Commerce and Claim Submission sections of our website for more information on electronic claim submission and other electronic transactions.

Paper Claims**Facility Providers**

Facility providers filing paper claims with BCBSIL must use the UB-04 claim form. For assistance with completing the UB-04 claim form, refer to the [National Uniform Billing Committee \(NUBC\)](#) website.

Professional Providers

Professional providers filing paper claims with BCBSIL must use the CMS-1500 claim form. For assistance with completing the CMS-1500 claim form, refer to the [National Uniform Claim Committee \(NUCC\)](#) website. Contact your print vendor to request a supply of paper claim forms. The form also may be ordered online at <http://bookstore.gpo.gov>, or by calling 202-512-1800.

Paper Claim Submission

Paper claims should be sent to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

Medicare Crossover

Crossover is the automatic process by which Medicare sends an electronic supplemental claim to private insurers. The electronic claim contains claim and remittance data used to calculate secondary payment liability. The claim and remittance information is released to an insurer based on a membership listing that the insurer sends to Medicare.

CMS has consolidated the Medicare crossover process from many crossover contractors to one contractor, Coordination of Benefits Contractor ("COBC"). Under this arrangement, COBC sends all supplemental claims to private insurers.

It is not necessary in most instances for contracted providers to submit either an electronic or a paper claim to BCBSIL, because we receive the electronic crossover claim. There are some situations when a claim does not crossover because the member's Health Insurance Claim Number (HICN) does not match our membership file. It is only when a claim does not crossover that providers need to file an electronic claim with BCBSIL.

We will reject paper secondary claims when we have established a verified crossover arrangement for a member through a positive match with the member's Medicare HICN. In those situations where there is no positive match, we will continue to process Medicare primary, BCBS secondary claims with existing procedures.

Before submitting a supplemental claim to BCBSIL, check to see if the claim automatically crossed over:

- The Medicare remittance advice will contain a message that the claim was forwarded through the crossover process.
- Crossover claim payments are highlighted with the message, "Medicare Crossover Claim" on the ERA, EPS or PCS.

Note: COBC will not crossover supplemental claims until claims have left the Medicare 14-day payment floor. For example:

- Electronic claims processed on July 7, will be released to the supplemental insurer after a 14-day payment floor, July 21.
- Paper claims processed on July 7, will be released after the 29-day payment floor instituted under the Deficit Reduction Act (DRA), August 5.

Do not resubmit a rejected claim by paper, because it will deny as a duplicate. Contracted providers must submit the rejected claim for review. Please follow the usual review request process by completing the appropriate form on the [Forms page](#) on our Provider website.

Coinsurance, Deductible

Contracted providers agree to bill the Plan for payment prior to charging the member for any deductible or coinsurance amount. Subsequent to receipt of payment from the Plan, the contracted provider shall bill the member for any deductible or coinsurance amount payable under the contract.

Copayments

Contracted providers may bill covered persons for copayment amounts at the time of service. Copayments should be listed on the member's ID Card. However, some employer groups choose not to display the copayment amount on the ID Card. Copayment amounts can be determined electronically by using Availity or Experian Health, or by calling the BCBSIL Provider Telecommunications Center (PTC) at 800-972-8088.

Member Liability Estimator (MLE)

The Member Liability Estimator (MLE), available through BCBSIL, will review the available information submitted, including primary diagnosis, procedures performed, available benefits and contractual allowances. Then the MLE will calculate an estimated out-of-pocket cost for office and outpatient services provided to BCBSIL members. Refer to the [Provider Tools page](#) in the Education and Reference Center of our website for additional information.

The contracted provider understands and agrees that by using the MLE, available through BCBSIL, or any other third party, that it agrees to the following terms and conditions:

- **MLE is not a guarantee of payment. Benefits will be determined once a claim is received by BCBSIL and will be based upon, among other things, the member's eligibility, benefits, limitations and exclusions and the terms of the member's certificate of coverage in effect on the date services are rendered.**
- The use of an MLE is to provide an estimate of the potential out-of-pocket costs that a member may be responsible for at a particular point in time.
- MLE is not a substitute for a predetermination, prior authorization or a Radiology Quality Initiative (RQI) number.
- A number of factors may impact the member's actual claim liability from the time an estimate is given to the time the claim is actually adjudicated, including, but not limited to, claims received but not yet adjudicated, medical policy and coordination of benefits and eligibility. Therefore, the member's actual liability may be different than the amount displayed by the MLE on a particular date.
- The MLE shall not override the terms of the member's coverage at the time services are rendered. In the event of a conflict the terms of the member's coverage document shall control.
- MLE is not a claims adjudication system. Claims will not be adjudicated until and unless billed to BCBSIL.
- The contracted provider may not collect an amount greater than the amount listed by the MLE at the time of service.
- In instances where the contracted provider has collected more money than the member's actual liability, as listed on the provider's EPS or PCS, or the member's EOB, the contracted provider agrees to refund the member within 30 days from the date the Contracted provider is notified by the EPS, PCS or any other documentation sent to the contracted provider, either in writing or electronically.
- In the event the overpayment is not returned to the member within this time frame, BCBSIL will be permitted to deduct the overpayment from future claim payments due to the contracted provider.

Note: BCBSIL reserves the right to revise the foregoing at any time without advance notification.

Balance Billing and Hold Harmless Provisions

All providers who contract with BCBSIL agree to accept a specific amount as full payment for each service covered by the patient's plan. The contracted provider agrees to bill BCBSIL before they ask for the patient's coinsurance and deductible, and they must not bill patients for any remaining balance above the agreed upon fee. If a contracted provider has balance billed one of our subscribers, we will notify the contracted provider and the subscriber that balance billing is not permitted under the contracted provider's contract.

BCBSIL also prohibits the contracted provider from charging patients for services that are deemed not medically necessary, unless the member requests the services, the contracted provider informs the member of his or her financial liability, the member chooses to receive the service(s) and the member accepts financial responsibility in writing. The contracted provider should document such notification to the member in the contracted provider's records. Both contracted hospitals and physicians have agreed to this provision in their contracts.

Participating Provider Retroactive Effective Date Requests

- No provider is considered to be a participating provider until they have completed the BCBSIL credentialing process and have been approved by BCBSIL (see the Credentialing Standards section for full requirements).
- Claims received prior to appointment or reappointment to the network may be treated as out-of-network until the provider has met all network requirements including but not limited to credentialing.
- On a case-by-case basis, BCBSIL reserves the right, in its sole discretion, to retroactively adjust effective dates. A provider must notify BCBSIL within 30 days of the appointment date to request consideration for a retroactive effective date. Any requests for a retroactive effective date that are granted by BCBSIL shall not be greater than 60 days from the approved provider's appointment date.
- Providers are strongly encouraged to submit all necessary documentation for participation at least 60 day prior to the intended effective date.
- Once credentialed, all providers are expected to comply with recredentialing standards.
- If a provider does not comply with recredentialing requirements before the current recredentialing cycle ends, BCBSIL reserves the right to treat all such claims as out-of-network.
- Providers will hold members harmless for dollar amounts over the Schedule of Maximum Allowance and any out-of-network member liability as a result of the provider's failure to complete the credentialing process in accordance with the terms set forth here and within BCBSIL's credentialing policies.
- If a provider is terminated for not meeting recredentialing requirements, the provider will have 30 days from the termination date to rectify and apply for reinstatement. Providers who remain terminated beyond 30 days will have to reapply to the network under the normal course of business.

Reimbursement and Statement Reporting

The Participating Agreement between the contracted provider and BCBSIL now includes the following statements that have been inserted in the Billing and Reimbursement section, Article IV, Section 2, emphasizing the importance of participating in electronic transactions:

The PPO Plus Provider agrees to use his/her best efforts to participate with the Plan's Electronic Funds Transfer (EFT) under the terms and conditions set forth on the Electronic Funds Transfer Agreement. The PPO Plus Provider also agrees to use his/her best efforts to participate with the Plan's Electronic Remittance Advice (ERA) as described on the Electronic Remittance Advice (ERA) Enrollment Form.

Please note: This Provider Manual is incorporated by reference into the PPO contract of all professional providers. As such, the language above applies to all existing professional PPO providers, effective Oct. 1, 2010.

Electronic Payment and Remittance Options

Both facility and professional providers may take advantage of the following electronic options that offer greater convenience, efficiency and security of information.

Electronic Funds Transfer (EFT) is a secure method of claims payment. BCBSIL electronically transfers funds directly into the bank account of your choice.

Electronic Remittance Advice (ERA) is a HIPAA compliant electronic file that includes claim payment and remittance data. The ERA is received the day after claim finalization. The purpose of the ERA is to enable automated posting to your 835-compatible patient accounting system.

Electronic Payment Summary (EPS) provides the same payment information as the paper PCS. It is received in your office the same day your ERA is delivered and can help streamline the payment and account reconciliation process.

To get started with EFT, ERA and EPS, visit the Claims and Eligibility/Electronic Payment and Remittance section of our Provider website.

Paper Provider Claim Summary (PCS)

As noted above, electronic payment and remittance options are preferred. For providers who are not enrolled for EFT and ERA/EPS, the PCS is a paper notification statement or voucher that is mailed with the payment, if applicable, to BCBSIL contracted providers after the processing of a claim has been completed. The content of each summary varies based upon the subscriber's benefit plan and services rendered, and explains payment, remittance information and any amount of the bill that is the patient's share. The voucher may include multiple transactions.

Refer to the appendix for PPO Facility Provider Claim Summary Example and PPO Professional Provider Claim Summary Example.

Reimbursement for Facility Providers

The base contract that is in effect with nearly all Illinois hospitals is the Plan contract. This contract automatically renews annually unless cancelled. The terms of this agreement is based on the hospital's cost, plus an agreed upon margin (typically 5%) for inpatient services and charges for covered services for outpatient services. The contractual allowance represents the difference between the total amount paid to the hospital during the year and the total actual cost of the care provided (cost + 5% margin).

Illinois hospitals that have PPO-specific contracts will always have Plan contract agreements. Illinois hospitals can also have specific contracts for other products/networks (e.g., HMO, Blue Choice PPOSM, Blue HPNSM). The terms of these contracts stipulate that the hospitals agree to prospective and stabilized rates coupled with utilization controls. The calculation of the contractual payment is typically a per diem for inpatient services and a percentage

of covered charges with payment maximums or caps for outpatient services. The claim's contractual allowance represents the difference between the contractual payment and the net covered charge.

Illinois Ancillary facilities such as Coordinated Home Care (CHC), Hospice, Skilled Nursing Facilities, Renal Facilities, Surgi-Centers, and Substance Abuse Facilities, may also have a contract with BCBSIL. Payment structure is typically a payment maximum or per diem. The claim's contractual allowance represents the difference between the contractual payment and the net covered charge.

All contracted BCBSIL facility providers receive a monthly or quarterly Experience Report that lists all claims, accompanied by a cover letter that summarizes the figures for the year-to-date. The cover letter includes the repayment terms. The amount due must be paid within 30 days, unless providers participate in the Uniform Payment Program (UPP), in which case the amount due is deducted from the next month's UPP checks.

The Experience Report and cover letter are available electronically through Experian Health.

Refer to the appendix for Sample PPO and HMO Experience Reports and Experience Report Sample Cover Letter.

Uniform Payment Program (UPP)

The UPP system of payment is a method of reimbursement designed to equalize payments to Blue Cross facilities. BCBSIL's PPO contracted facilities must demonstrate that they have an effective utilization program and will participate in cost containment activities. Most PPO and EPO facilities are on the UPP system. BCBSIL then provides an accelerated, predictable, weekly payment that approximates an average week's worth of Blue Cross business. The advance is monitored on a weekly basis and adjusted as necessary. Over a period of time the advance should approximate claims processed, given the absence of disruption to normal performance goals for claim processing activities.

The purpose of the UPP is to provide a cash flow incentive to contracted providers in consideration for having utilization review programs in place that favorably impact admissions and length of stays of Blue Cross subscribers. In addition, the UPP is also used to facilitate the collection of contractual allowances.

Providers participating in the UPP will usually receive:

- **An advance weekly check**
UPP checks are usually produced every Wednesday evening (with a Friday date) and mailed or sent via EFT to the provider's bank account. Thus, most providers have an advance that is expected to approximate the claims that will be processed during that week. *See the example on the following page for details on how the amount of the advance is calculated each week.*
- **Non-payment vouchers (PCS) without a check attached**
As non-payment vouchers are received, the provider credits the subscriber's ledger and a corresponding debit is posted to their advance account. It is the provider's responsibility to maintain this daily log of non-payment vouchers so that the voucher numbers and amounts can be matched against the information reported on the UPP monthly summary.
- **A monthly UPP Statement listing details (vouchers, advances, credits, and weekly/monthly balances) of the month's activity.** This statement is available via Experian Health.

Note: Those providers receiving EFT will receive an electronic UPP check breakdown (report #0500) via their assigned clearinghouse.

Calculations for Weekly UPP Check

Each contracted provider's balance and advance amount are reviewed on a weekly basis. Adjustments to the advance are generally made when the provider's account balance falls outside the targeted range of a high of five days of business and a low equivalent to + 3.5 days of business (70 to 100 percent of average weekly claims processed).

Gross advance amount determining factors:

- Current UPP balance
- Average weekly claims processed (based on the previous three months of activity)
- Previous week's advance

Generally, if a contracted provider's balance falls below the targeted range, the advances are increased until the target is achieved. **The increased gross amount is calculated as follows:**

Average claims processed times 1.7 less the current balance. For example:

- | | |
|-----------------------------------|----------|
| • Weekly average claims processed | \$10,000 |
| • Current UPP balance | \$ 4,000 |
| • Previous week's UPP advance | \$10,000 |
| • New advance amount | \$13,000 |

If the balance exceeds average claims processed by less than 20 percent, the advance is decreased until the balance is brought back in line. **The decreased gross amount is calculated as follows:**

Average claims processed times 2 less the current balance. For example:

- | | |
|-----------------------------------|----------|
| • Weekly average claims processed | \$10,000 |
| • Current UPP balance | \$11,000 |
| • Previous week's UPP advance | \$10,000 |
| • New advance amount | \$ 9,000 |

If the balance exceeds average claims processed by more than 20 percent, the advance is decreased until the balance is brought back in line. **The decreased gross amount is calculated as follows:**

Average claims processed times 2.2 less the current balance. For example:

- | | |
|-----------------------------------|----------|
| • Weekly average claims processed | \$10,000 |
| • Current UPP balance | \$15,000 |
| • Previous week's UPP advance | \$10,000 |
| • New advance amount | \$ 7,000 |

Once the balance is back in the targeted range, the advance amount will be set at the weekly average as follows

- | | |
|-----------------------------------|----------|
| • Weekly average claims processed | \$10,000 |
| • Current UPP balance | \$ 9,000 |
| • Previous week's UPP advance | \$ 8,000 |
| • New advance amount | \$10,000 |

All calculations will be adjusted for the Processing Factor as necessary.

Posting Example

A patient's account is \$5,000 and they have a comprehensive 100 percent contract.

Gross UPP amount	\$5,000
Incentive contractual allowance	\$1,000
HMO contractual allowance	\$ 500
Net UPP amount	\$3,500

The posting would be:

- a) To record the receipt of the weekly UPP check
- b) To post the receipt of the UPP voucher

UPP Clearing Account
5,000 (a)
5,000 (b)

Incentive Contractual Allowance
1,500 (a)

Cash Account
3,500 (a)

Patient's Ledger
5,000 (b)

Refer to the appendix for Uniform Payment Program (UPP) Monthly Statement Sample.

For a more detailed explanation of the UPP process, please contact your assigned [Provider Network Consultant \(PNC\)](#).

Adjustments to Blue Cross Facility Claims

Late Charges and Corrected Claims

Late charges are charges that were not included in the original billing. All late charges and credits must be filed within 90 days of the original claim payment.

- Late charges should be submitted electronically in the UB-04 format. (Blue Cross no longer uses forms BC55 or BC177 to submit late charges.)
- Submit **Type of Bill (TOB) X15 or X35**

Corrected claims are submitted to correct the original claim.

- Submit **TOB X17 or X37** to replace a claim which includes additional charges that were not included in the original claims.

The following message will appear on your EPS when late charges, corrected or replacement claims are submitted:

The related ANSI Reason code B13 will appear on the ERA.

The following message will appear on your paper PCS when late charges, corrected or replacement claims are submitted:

This is a late charge or corrected claim. If any additions or corrections were necessary, the original claim has been adjusted.

If a late charge or corrected claim is submitted and we have no original claim on file, that claim will be processed as if it were the original claim.

Your EPS message will state:

We have adjusted the original claim for this service.

Your PCS message will state:

We have adjusted the original claim for this service.

Reimbursement for Professional Contracted Providers

Contracted Providers

- Members must use BCBSIL contracted providers to maximize their benefits.
- BCBSIL pays contracted providers directly for all covered services.
- The member's benefit plan determines the reimbursement
 - Members with PPO and Blue Choice PPO policies – Schedule of Maximum Allowances (SMA)
 - Members with Blue HPN – IL HPN Fee Schedule
- Contracted providers receive an EPS or PCS that indicates the amounts billed and paid, covered services, non-covered services, deductible and coinsurance and patient share.

The SMA is based on a payment methodology called the Resource Based Relative Value Scale (RBRVS).

RBRVS has three main components:

1. Relative Value Units (RVU) that are weights assigned for specific services based on:
 - Work: The physician's resources, including time and effort intensity
 - Overhead/practice expenses (PE): Rent, salaries, equipment, supplies, etc.
 - Liability/malpractice (MP) insurance expenses
2. Geographic Practice Cost Index (GPCI)
 - Cost factors that reflect varying costs in different areas
 - A separate GPCI is applied to the RVU factors (work, overhead, liability) in each location
3. Conversion Factor
 - A number that converts relative weights created by RVUs and GPICs for each procedure code into payment dollars. The weights are multiplied by the conversion factor to obtain the payment.

RBRVS Payment Formula

$(\text{Work RVU} \times \text{Work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI}) \times \text{Conversion Factor} = \text{Payment Amount}$

BCBSIL's HMOs and MG/IPA Responsibility

Contracted Medical Groups (MGs) and Independent Practice Associations (IPAs) are paid a monthly capitation fee for all HMO members enrolled with their group. The following chart outlines the typical reimbursement responsibility for the MG/IPA and the HMO. For more detailed information visit the HMO Claims Processing section of the Provider Manual.

HMO Responsibility	IPA Responsibility
<ul style="list-style-type: none"> ▪ Facility charges for: <ul style="list-style-type: none"> -Inpatient stays -Outpatient surgery -Out-of-area (NGA services) -Emergency room visit -Behavioral Health ▪ Observation Units ▪ Professional Emergency Admission - Charges prior to IPA notification ▪ Professional charges for out of area emergency room visits ▪ Hospice ▪ Skilled Nursing Facility ▪ All charges for: <ul style="list-style-type: none"> -Extraction of completely bony impacted teeth -Voluntary Sterilization -Organ Transplants (approved by HMO) -Transgender Services (approved by HMO) ▪ Prescription Drugs ▪ Vision Exam/Eyewear ▪ Durable Medical Equipment (If referred to HMO Network Provider) ▪ Skilled Home Health (If referred to HMO Network Provider) ▪ Outpatient dialysis (if referred to HMO Network Provider) ▪ Orthotics/Prosthetics (O&P) (If referred to HMO Network Provider. Note: Some O&P items are always IPA risk. Contact IPA for more details.) ▪ Medical Supplies (not from an MD office) ▪ Ambulance Services ▪ ART/Infertility (If referred to HMO Network Provider) ▪ Outpatient Private Duty Nursing for Blue Precision HMOSM, BlueCare DirectSM and Blue FocusCareSM 	<ul style="list-style-type: none"> ▪ Professional Fees for: <ul style="list-style-type: none"> -Inpatient -Outpatient -In-area Emergency Room visit -Behavioral Health ▪ Outpatient Diagnostics ▪ Outpatient Rehabilitation ▪ Medical Supplies from MD office ▪ Injections ▪ Immunizations ▪ Well child care ▪ Periodic Health Exams ▪ Dental (Some dental related services, contact IPA for more details) ▪ Orthotics/Prosthetics (O&P) (If referred to provider other than HMO Network Provider. Note: Some O&P items are always IPA risk. Contact IPA for more details.) ▪ Outpatient Radiation and Chemotherapy ▪ Outpatient Inhalation (Respiratory) Therapy ▪ Outpatient Hearing Screening ▪ Outpatient Ancillary Services ▪ Outpatient treatment ▪ Outpatient dialysis (if referred to provider other than HMO Network Provider) ▪ Day Rehabilitation ▪ ART/Infertility (If referred to provider other than HMO Network Provider) ▪ Durable Medical Equipment (if referred to provider other than HMO Network Provider) ▪ Skilled Home Health (if referred to provider other than HMO Network Provider or for an Ambulatory member)

Note: This list is not all-inclusive.

Refunds/Payment Recovery Program

The Payment Recovery Program (PRP) allows BCBSIL to recoup overpayments made to BCBSIL contracted facilities and professional providers in the PPO, Blue Choice PPO, Blue HPN and HMO product networks when payment errors have occurred. Overpayments can occur as a result of duplicate payments, non-covered services, COB, etc.

Refund Process

The following process is used to recover overpayments identified by BCBSIL:

1. A refund request letter, explaining the reason for the refund is sent to providers; it includes a remittance form and return address envelope. Contracted providers with access to our Electronic Refund Management (eRM) tool have the option to receive overpayment notifications via email.
2. If we do not receive a response to our initial communication, a follow up letter/email is sent asking for payment.
3. If we do not hear from the contracted provider by telephone, in writing or through eRM, or the contracting provider does not return the amount of the overpayment within 90 days from the date of the follow up letter, BCBSIL will recover the overpayment by offsetting current claim payments by the amount due to us.
4. The patient information and recovery amount are explained on the EPS or PCS, as well as the ERA. If applicable, a summary will appear on the UPP Monthly Statement.

Refer to the appendix for Refund Request Letter Sample, Refund Request Follow-up Letter Sample and Provider Claims Summary (PCS) Sample.

The EPS or PCS will display:

- The total amount recouped toward the overpayments
- The net amount after recoupment has been applied
- Information regarding the specific overpaid patient account (i.e., patient name, patient account number, service dates, etc.), the amount of overpayment recouped and the overpayment reason

The ERA will include:

- Information in a PLB segment when an overpayment is recovered by BCBSIL. The ANSI 835 version 5010A1 will be displayed as follows:
 - **PLB*12345697890*20121231*WO:02012123456789X0099999999*25.30~**
 - **PLB01 = National Provider Identifier (NPI)**
 - **PLB02 = Fiscal Period (CCYYMMDD)**
 - **PLB03-01 = Adjustment Identifier (WO = Overpayment Recovery)**
 - **PLB03-02 = Provider Adjustment Identifier = DCN # will be provided, as well as Patient Control Number**
 - **PLB04 = Provider Adjustment Amount**

The UPP Monthly Statement will display:

- A separate line for recoupment amounts if a refund is not received

Provider Credit Balances

Contracted professional and facility providers may submit unsolicited refunds when they identify a credit balance. Credit balances are submitted for the following reasons:

- COB Credit** Payment has been received under two different BCBS numbers, or from BCBS and another carrier. Indicate name, address and amount paid by other carrier.
- Overpayment** BCBS payment in excess of amount billed; provider has posted a credit for supplies or services not rendered; or provider canceled charge for any reason.
- Duplicate Payment** A duplicate payment has been received from BCBS under the same group and subscriber number.
- Not Our Patient** Payment has been received for a patient that did not receive services from you.
- Medicare Eligible** Payment for the same service has been received from BCBS and the Medicare intermediary.
- Workers' Compensation** Payment for the same service has been received from BCBS and a Worker's Compensation carrier.

Submitting a Refund

Online – Electronic Refund Management (eRM)

UPP and non-UPP contracted professional and facility providers can electronically submit refunds to BCBSIL using the eRM tool. The refunds are applied real-time, eliminating the need to mail in a paper form. **Non-UPP providers** have the option to refund BCBSIL by check or by letting BCBSIL deduct the dollars from a future claim payment. **For UPP providers**, the dollars will be deducted from future payments. If a contracted provider identifies a credit balance, the request may be submitted online. The refund payment can be submitted by check or deducted from future payments.

Manual (Paper) Submission

Professional contracted providers not using eRM may use the [Provider Refund Form](#) located in the Education and Reference Center under Forms on our website. The completed Provider Refund Form must be submitted with payment to Blue Cross and Blue Shield of Illinois, Claims Overpayments, Dept. CH 14212, Palatine, IL 60055-4212

More Information About eRM

eRM is an online refund management tool that features many practice enhancing components, which will help simplify overpayment reconciliation and related processes, and is available to contracted providers at no additional charge. Registration with Availity is required prior to obtaining access to eRM, Visit availity.com for details on how to become a registered user.

eRM offers the following features:

- **Single sign-on** – Current users can access eRM through Availity.
- **Electronic notification of overpayments** – Contracted providers have the option to replace paper requests for claim refunds with electronic notification. Contracting professional and facility providers receive a daily or weekly email that summarizes overpayment requests for each National Provider Identifier (NPI). This helps reduce the cost of maintaining overpayment records.
- **Ability to settle overpayment requests online** – BCBSIL can deduct the overpayment from a future claim payment. Details will appear on the EPS or PCS. Information in the eRM transaction history can also assist with recoupment reconciliations.
- **Ability to inquire about, dispute or appeal requests online** – If contracted providers have any disagreements or would like more information for each request, the request can be submitted online.
- **View overpayment requests** – Contracted providers can view and search/filter all new, outstanding and closed refund requests that contain an NPI related to an office or facility. Contracted providers can also view more details including claim, patient account number, service dates, overpayment reason, etc. The eRM tool delivers a real-time transactional history for each refund request, showing a complete audit trail for tracking when an action was taken on a particular item and who performed it (including closed requests).
- **Pay by check** – Contracted providers may select one or multiple requests and refund BCBSIL by mailing a check. Contracted providers will be asked to include a system generated remittance form showing the refund details (generated within eRM). When BCBSIL receives the refund check, the check number that was sent to settle the overpayment will be noted.
- **Submit unsolicited refunds** – Contracted providers can submit a credit balance online and refund the payment by check, or BCBSIL can deduct the refund from a future claim payment. The information will still be on the EPS or PCS. The details will be in the eRM transaction history to assist with all recoupment reconciliations. No other contact (e.g., phone inquiry) is necessary for the credit balance/overpayment situations.
- **System Alerts** – Contracted providers will receive notification via the eRM system in certain situations, for example if BCBSIL has responded to the inquiry or if a check has been stopped or returned to BCBSIL due to a bad address.

The eRM tool also includes a Claim Inquiry Resolution (CIR) function that enables submission of a variety of online requests for reconsideration on finalized claims. The CIR tool can be accessed via a tab within the eRM system.

How to Gain Access to eRM

Availity Users

Click on the Payer Spaces tab, select the BCBS link, select resources and the eRM link. If you are unable to access the Refund Management eRM link, please contact your Availity Administrator. If you do not know who the Availity Administrator is, select 'My Administrators' link under 'My Account Dashboard'. You may also contact Availity Client Services at 800-AVAILITY (282-4548) for assistance or visit [availity.com](https://www.availity.com) for more information.

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Checking eligibility and/or benefit information and/or the fact that a service has received prior authorization or been pre-notified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, call the number on the member's ID card.

This material is for informational purposes only and is not intended to be a definitive source for coding claims. Health care providers are instructed to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials.

Change Healthcare is an independent company providing coding software to BCBSIL. Change Healthcare is solely responsible for the software and all the contents. Cotiviti, INC. (Cotiviti) is an independent company that provides medical claims administration for BCBSIL. Cotiviti is solely responsible for the products and services that it provides. Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. eviCore is an independent specialty medical benefits management company that provides utilization management services for BCBSIL. eviCore is wholly responsible for its own products and services. Experian Health is an independent third party vendor and is solely responsible for its products and services. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Change Healthcare, Cotiviti, Availity, eviCore and Experian Health. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

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Appendix

Confidential and Proprietary

PPO Facility Provider Claim Summary Example/Field Explanations



DATE: MM/DD/YY
PROVIDER NUMBER: 0000000000
VOUCHER NUMBER: 123456789
TAX IDENTIFICATION NUMBER: 987654321

5 ABC FACILITY
123 MAIN STREET
ANYTOWN, IL 60000

PROVIDER CLAIM SUMMARY

ANY MESSAGES WILL APPEAR ON PAGE 2

*****INPATIENT

6 PATIENT: JOHN DOE **8** PATIENT NO: 000000 **10** ADMIT DATE **11** FROM DATE **12** END DATE
7 CLAIM NO: 0000000000000000X **9** ICN NO: MM/DD/YY MM/DD/YY MM/DD/YY

13 DAYS TRT	14 ORIGIN CODE	15 PROVIDER CHARGE	16 BLUE CROSS PAID	17 TOTAL AMOUNT PAID	18 MANAGED CARE DEDUCTION(S)	19 TOTAL PATIENT PORTION
012	03	\$1,200.00	\$960.00	\$960.00	\$0.00	\$240.00

MESSAGES/REASONS: OA

PATIENT: JOHN DOE PATIENT NO: 000000 ADMIT DATE FROM DATE END DATE
CLAIM NO: 0000000000000000X ICN NO: MM/DD/YY MM/DD/YY MM/DD/YY

DAYS TRT	ORIGIN CODE	PROVIDER CHARGE	BLUE CROSS PAID	TOTAL AMOUNT PAID	MANAGED CARE DEDUCTION(S)	TOTAL PATIENT PORTION
010	03	\$1,000.00	\$800.00	\$800.00	\$0.00	\$200.00

MESSAGES/REASONS: OA

PROVIDER CLAIMS AMOUNT SUMMARY

20 PROVIDER CHARGES:	\$2,200.00	I	23 PATIENT PORTION:	\$440.00
21 BLUE CROSS AMOUNT PD:	\$1,760.00	I	24 AMOUNT PAID:	\$1,760.00
22 MANAGED CARE DEDUCTION(S):	\$0.00	I	25 NUMBER OF CLAIMS:	02

AMOUNT PAID TO PROVIDER:	\$80.00	AMOUNT OVER U & C:	\$0.00
AMOUNT PAID TO MEMBER:	\$50.00	AMOUNT OF SERVICES NOT COVERED:	\$19.00
NUMBER OF CLAIMS:	1	AMOUNT PREVIOUSLY PAID:	
		AMOUNT OVER MAXIMUM ALLOWANCE:	\$11.00

ORIGIN CODE 01 IS HCMS

ORIGIN CODE 02 IS SCMS

ORIGIN CODE 03 IS BLUE CHIP

26 MESSAGES/REASONS:
(OA) A CONTRACT COINSURANCE HAS BEEN TAKEN

PPO Facility Provider Claim Summary Sample/Field Explanations (Continued)

1	Date	Date the summary was finalized
2	Provider Number	The facility's National Provider Identifier number
3	Voucher Number	The number assigned to the check for this voucher
4	Tax Identification Number	The number which identifies your taxable income
5	Provider Name & Address	The provider's name and address that rendered the services
6	Patient	The name of the individual who received the service
7	Claim Number	The Blue Cross number assigned to the claim
8	Patient Number	The patient's account number assigned by the provider
9	ICN Number	The number that identifies the group and member insured by BCBSIL
10	Admit Date	The date the patient was admitted to the provider for care (the Start of Care date could be different than the From/End dates).
11	From Date/End Date	Indicates the beginning and ending dates of services rendered
12		
13	Days Trt	The total number of service days or treatments
14	Origin Code	BCBS identifying system codes
15	Provider Charge	The amount billed for each service
16	Blue Cross Paid	The amount paid for each service
17	Total Amount Paid	The amount paid to the provider
18	Managed Care Deduction(s)	The amount of any applicable cost containment or PPO reductions
19	Total Patient Portion	The total amount that is the patient's responsibility
20	Provider Charges	Total provider charges for this voucher
21	Blue Cross Amount Paid	Total Blue Cross payment for this voucher
22	Managed Care Deduction(s)	Total cost containment or PPO reductions for this voucher
23	Patient Portion	Total amount for which the patient is responsible
24	Amount Paid	Total amount paid for claims on this voucher
25	Number of Claims	Number of claims for this voucher
26	Messages/Reasons	This area includes the narrative for any codes relating to a denial of services or reduction in the amount paid

PPO Professional Provider Claim Summary Example/Field Explanations



5 ABC MEDICAL GROUP
123 MAIN STREET
ANYTOWN, IL 60000

DATE: MM/DD/YY
PROVIDER NUMBER: 0001112222
CHECK NUMBER: 123456789
TAX IDENTIFICATION NUMBER: 987654321

1
2
3
4

PROVIDER CLAIM SUMMARY

ANY MESSAGES WILL APPEAR ON PAGE 1

6 PATIENT: JOHN DOE
7 PERF PRV: 1234567890
8 CLAIM NO: 0000611112222344C

IDENTIFICATION NO: P06666-XOC123456789
PATIENT NO: 001001

11 FROM /TO DATES	12 PS**	13 PAY	14 PROC CODE	15 AMOUN T BILLED	16 ALLOWABLE AMOUNT	17 SERVICES NOT COVERED	18 DEDUCTIONS/OTHER INELIGIBLE	19 AMOUNT PAID
10/10-10/10/10	03	PPO	99213	59.00 59.00	43.33 8.33	15.67 (1) 15.67	35.00 (2) 35.00	8.33 8.33

20 AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$8.33

DEDUCTIONS/OTHER INELIGIBLE

21 CONTRACT DEDUCTIBLE:	35.00
22 TOTAL SERVICES NOT COVERED:	15.67
23 PATIENT'S SHARE:	\$35.00

24 AMOUNT BILLED:	\$59.00	AMOUNT OF SERVICES NOT COVERED:	\$15.67
AMOUNT PAID TO PROVIDER:	\$8.33	AMOUNT PREVIOUSLY PAID:	\$00.00
AMOUNT PAID TO MEMBER:	\$0.00	NUMBER OF CLAIMS:	1
RECOUPMENT AMOUNT:	\$0.00	NET AMOUNT PAID TO PROVIDER:	\$8.33

25 **PLACE OF SERVICE (PS)
03. PHYSICIAN'S OFFICE

MESSAGES:

- 26** (1). YOUR SUBMITTED CHARGE EXCEEDS THE MAXIMUM ALLOWANCE. AS A PARTICIPATING PHYSICIAN, YOU HAVE AGREED TO ACCEPT THIS PAYMENT IN FULL AND NOT BILL OUR MEMBER FOR THE AMOUNT EXCEEDING THE MAXIMUM ALLOWANCE.
- (2). A CONTRACT DEDUCTIBLE HAS BEEN TAKEN.

PPO Professional Provider Claim Summary Example/Field Explanations (Continued)

1	Date	Date the summary was finalized
2	Provider Number	The physician's National Provider Identifier number
3	Check or Voucher Number	The number assigned to the check for this summary
4	Tax Identification Number	The number which identifies your taxable income
5	Provider or Group Name & Address	The provider/group address who rendered the services
6	Patient	The name of the individual who received the service
7	Performing Provider	The rendering provider's NPI
8	Claim Number	The Blue Shield number assigned to the claim
9	Identification Number	The number which identifies the group and Member insured by BCBSIL
10	Patient Number	The patient's account number assigned by the provider
11	From/To Dates	Indicates the beginning and ending dates of services rendered
12	PS	Place of service
13	PAY	Reimbursement payment rate that was applied in relationship to the member's policy type
14	Procedure Code	The code that identifies the procedure performed
15	Amount Billed	The amount billed for each procedure/service
16	Allowable Amount	The highest amount BCBSIL will pay for a specific type of medical procedure.
17	Services not Covered	Non-covered services according to the member's contract
18	Deductions/Other Ineligible	Program deductions, copayments and coinsurance amounts
19	Amount Paid	The amount Blue Shield paid to provider for this claim
20	Amount paid to provider for this claim	The amount Blue Shield paid to provider for this claim
21	Contract Deductible	The deductible amount applied to this claim (patient's responsibility)
22	Total Services not Covered	Non-covered services according to the member's contract
23	Patient's Share	Amount patient pays. Providers may bill this amount to the patient
24	Claim Summary Section Totals	This section indicates how this claim was adjudicated
25	Place of Service (PS)	The description for the place of service code used in field 14
26	Messages	The description for messages relating to: <ul style="list-style-type: none"> • Non-covered services • Program deductions • PPO reductions

Sample PPO Experience Report/Field Explanations

HEALTH CARE SERVICE CORPORATION

PPO EXPERIENCE REPORT

PPO DISCOUNT STATUS: Y

PROVNAME: ABC FACILITY

BLUE CROSS NO. 0000000000

REPYEAR: MM/DD/YYYY

SETTING: INPATIENT CLAIM TYPE: INPATIENT

FOR THE MONTH ENDED YYYY/MM/DD

With Bonus Settlement for the Month Ended YYYY/MM/DD

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
LAST NAME	F I	PROVIDER PATIENT NUMBER	SUB No.	GROUP NO.	ADMIT DATE	DISCH DATE	CA-SES	TOTAL DAYS	MED SURG DAYS	ICU DAYS	PSY DAYS	SUB ABUSE DAYS	TYPE	PRIMARY ICD-9 PROCOD	DRG IP CPT OP	SERV UNITS	COVERED CHARGES	TOTAL OTHER PMTS APPLIED	NET COV CHARGES	PPO PAYMENT	PPO ALLOWANCE
ADAMS	J	000000000	0000000111111111	123456	mm/dd/yy	mm/dd/yy	1	1	1	0	0	0	MLT DIEM	9604	449	0	14,817.37	2,798.00	11,238.97	.00	11,238.97
ADAMS	J	000000000	0000000111111111	123456	mm/dd/yy	mm/dd/yy	-1	-1	-1	0	0	0	MLT DIEM	9604	449	0	-14,817.37	-2,798.00	-11,238.97	.00	-11,238.97
BLACK	P	000000000	0000000333333333	XOP123	mm/dd/yy	M	0	0	0	0	0	0	OB	741	371	0	2,581.20	.00	2,581.20	.00	2,581.20
BURNS	S	000000000	0000000888888888	123456	mm/dd/yy	mm/dd/yy	1	5	5	0	0	0	LESSEROF	7935	210	0	10,307.24	313.19	9,994.05	9,994.05	.00
COLLINS	R	000000000	0000000444444444	123456	mm/dd/yy	mm/dd/yy	0	0	0	0	0	0	OB	640	391	0	2,974.00	.00	2,974.00	1,827.00	1,147.00
DAVIS	K	000000000	0000000555555555	123456	mm/dd/yy	mm/dd/yy	1	8	5	3	0	0	MLT DIEM	5779	303	0	92,082.22	25,126.00	305.69	.00	305.69
DOE	J	000000000	0000000666666666	P12345	mm/dd/yy	mm/dd/yy	1	2	0	2	0	0	MLT DIEM	3761	111	0	9,364.20	904.52	8,459.68	2,807.48	5,652.20
TOTAL CLAIM							3	15	10	5	0	0					117308.86	26344.42	24314.62	14628.53	9686.09
TOTAL INCURRED THRU 2005/12/31							3	15	10	5	0	0					117308.86	26344.42	24314.62	14628.53	9686.09
ADKINS	J	000000000	0000000999999999	123456	mm/dd/yy	mm/dd/yy	0	0	0	0	0	0	OB		391	0	1,889.00	84.80	1,804.20	1,193.20	611.00
ADAMS	M	000000000	0000000111111111	P12345	mm/dd/yy	mm/dd/yy	1	8	8	0	0	0	MLT DIEM		089	0	36,805.00	.06	36,804.94	23,559.94	13,245.00
BROWN	P	000000000	0000000222222222	XOP123	mm/dd/yy	mm/dd/yy	1	7	7	0	0	0	MLT DIEM	3950	554	0	79,217.80	100.00	79,117.80	20,515.00	58,602.80
COLLINS	R	000000000	0000000333333333	123456	mm/dd/yy	mm/dd/yy	1	3	0	3	0	0	LESSEROF		390	0	11,461.00	.00	11,461.00	11,461.00	.00
DAVIS	K	000000000	0000000444444444	123456	mm/dd/yy	mm/dd/yy	1	1	1	0	0	0	MLT DIEM		143	0	19,817.00	53.20	19,763.80	2,891.80	16,872.00
EVANS	S	000000000	0000000555555555	P12345	mm/dd/yy	mm/dd/yy	-1	-2	0	-2	0	0	MLT DIEM	9671	475	0	-41,309.00	-1,854.71	-39,454.29	-5,955.29	-33,499.00
OTOOLE	M	000000000	0000000666666666	XOP123	mm/dd/yy	mm/dd/yy	0	0	0	0	0	0	OB		391	0	2,096.00	94.51	2,001.49	1,183.49	818.00

Sample PPO Experience Report/Field Explanations (Continued)

The Experience Report lists the following details on a claim by claim basis:

No.	Name	Explanation
1	Last Name	Last name of member.
2	FI	Member's first initial.
3	Provider Patient Number	Identification number assigned by provider.
4	Sub No.	Blue Cross member ID
5	Group No.	Member's BCBS group number.
6	Admit Date	Date of admission.
7	Disch Date	Date of discharge.
8	Cases	Each claim is listed as 1 case.
9	Total Days	The number of days paid on this claim.
10	Med Surg Days	Number of days not classified as ICU, Psych, SubAb, or Rehab.
11	ICU Days	Number of days paid for intensive level of care. Revenue Codes 174, 200-219.
12	Psy Days	Number of days paid for psych services.
13	Sub Abuse Days	Number of days paid for services related to substance abuse.
14	Type	A brief general description of the contract terms under which the service was discounted.
15	Primary ICD-9 ProcCd	Industry defined claim level code that identifies the primary medical services performed.
16	DRG IP CPT OP	DRG value for inpatient claims, HCPCS code for outpatient medical claims.
17	Serv Units	If CPT fee schedule applies and claim is outpatient, then units of service provided.
18	Covered Charges	Amount billed by provider.
19	Total Other Pmts Applied	Any other charge for which the member is liable, i.e., deductible and coinsurance, coordination of benefits, non-covered charges
20	Net Cov Charges	Net payment calculated before discount; covered charges less member share and other payments applied.
21	PPO Payment	The contracted payment which varies for different provider types; each facility must refer to the terms of their specific contract.
22	PPO Allowance	The difference between the contracted payment and the total covered Blue Cross charges is the contractual allowance due to Blue Cross.

Sample HMO Experience Report/Field Explanations

HMO ILLINOIS
HMOI EXPERIENCE REPORT

ABC HOSPITAL
HOSPITAL NO. 77

FOR THE MONTH ENDED YYYY/MM/DD
With Bonus Settlement for the Month Ended YYYY/MM/DD

HMO DISCOUNT FLAG: Y

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	
I/P OR O/P	LAST NAME	SUBSCR NUMBER	HOSPITAL CLAIM NO.	GROUP NUMBER	ADMIT DATE	DISCH DATE	REIMBURSEMENT TYPE	C A S E S	ACCUM CASE COUNT	DAYS	PCT FLG	NET COVERED CHARGES	DEDUCT & COPAYS	COORD. OF BENEFIT S	NONCOVERED CHARGES	BILLED CHARGES	HMO PAYMENT	HMO ALLOWANCE
I/P	ADAMS	0000000011111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	MED./SURG	1	00602	7		33,204.00	250.00	.00	.00	33,454.00	13,239.00	19,965.00
	ADAMS	0000000011111111	123456789	H12345	mm/dd/yy	mm/dd/yy	MED./SURG	1	00639	2		18,066.00	250.00	.00	.00	18,316.00	5,531.00	12,535.00
	BLACK	0000000011111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	OB CASE	1	00616	4		39,006.80	250.00	.00	.00	39,256.80	11,312.00	27,694.80
	BURNS	0000000011111111	123456789	H12345	mm/dd/yy	mm/dd/yy	ICU/MED.SRG.	0	00604	2		14,084.00	.00	.00	.00	14,084.00	9,240.00	4,844.00
	COLLINS	0000000011111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	ICU	1	00586	2		11,265.00	125.00	.00	12.00	11,402.00	9,115.00	2,150.00
	DAVIS	0000000011111111	123456789	H12345	mm/dd/yy	mm/dd/yy	NURSERY	0	00601	6		3,461.00	.00	.00	.00	3,461.00	4,572.00	-1,111.00
	DOE	0000000011111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	BOARDER BAPT	0	00586	3		8,079.00	250.00	.00	.00	8,329.00	5,680.00	2,399.00
	ADKINS	0000000011111111	123456789	H12345	mm/dd/yy	mm/dd/yy	MED./SURG	1	00657	4		2,203.00	.00	.00	.00	2,203.00	2,286.00	-83.00
	ADAMS	0000000011111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	MED./SURG	0	00609	1		9,431.00	.00	.00	.00	9,431.00	7,585.00	1,846.00
	BROWN	0000000011111111	123456789	H12345	mm/dd/yy	mm/dd/yy	OB CASE	0	00646	0		14,722.00	.00	.00	.00	14,722.00	5,781.00	8,941.00
	COLLINS	0000000011111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	ICU/MED.SRG.	0	00652	2		13,818.00	.00	.00	102.00	13,920.00	1,927.00	11,891.00
	DAVIS	0000000011111111	123456789	H12345	mm/dd/yy	mm/dd/yy	ICU	1	00603	3		9,246.00	600.00	.00	.00	9,846.00	10,084.00	-838.00
	EVANS	0000000011111111	123456789CP	H12345	mm/dd/yy	mm/dd/yy	NURSERY	1	00646	0		39,684.00	.00	.00	.00	39,684.00	11,562.00	28,122.00
	OTOOLE	0000000011111111	123456789	H12345	mm/dd/yy	mm/dd/yy	BOARDER BAPT	1	00578	1		-39,430.00	.00	.00	.00	-39,430.00	-11,562.00	-27,868.00

Sample HMO Experience Report/Field Explanations (Continued)

The Experience Report lists the following details on a claim by claim basis:

No.	Name	Explanation
1	I/P OR O/P	I/P = Inpatient O/P = Outpatient
2	Last Name	Last Name of member
3	Susbcr Number	Blue Cross Subscriber Number
4	Hospital Claim No.	Provider Patient Number. Identification number assigned by hospital which is unique for each patient outpatient episode or inpatient bill.
5	Group Number	Member's BCBS group number.
6	Admit Date	Date of admission.
7	Disch Date	Date of discharge.
8	Reimbursement Type	Identifies applicable reimbursement provision (e.g., Med/Surg per diem or OB Case Rate). In the HMO Discount Flag "N" section, it identified the reason the claim is not being discounted (e.g., Medicare primary). In the outcome bonus section (HMO Discount Flag "B"), the value is Bonus Payment.
9	Cases	Identifies inpatient case. A value of +1 for positive claims and -1 for claim reversals. Normal Newborn takes the value of 0.
10	Accum Case Count	Ignore. This is a case counter used for internal Blue Cross purposes.
11	Days	The number of days paid on this claim.
12	Pct Flg	Identifies claims paid based on a percentage discount. PCT FLG = Y when paid based on a percentage discount.
13	Net Covered Charges	This is the amount that Blue Cross paid up front.
14	Deduct & Copays	Deductibles, Coinsurance and Copayments for which the member is liable.
15	Coord of Benefits	Coordination of Benefit Amounts
16	Billed Charges	Total Billed Charges on the Claim
17	HMO Payment	The contracted payment which varies for different provider types; each facility must refer to the terms of their specific contract.
18	HMO Allowance	The difference between the contracted payment and the total covered Blue Cross charges is the contractual allowance due to Blue Cross.



Experience Report Sample Cover Letter



BlueCross BlueShield
of Illinois

MM DD YY

MARY M. SMITH
CHIEF FINANCIAL OFFICER
ABC FACILITY
123 MAIN STREET
ANYTOWN, ILLINOIS 60000

INTERIM
RECONCILIATION

DEAR MARY M. SMITH:

PLEASE FIND ATTACHED A SUMMARY OF YOUR PPO CLAIM EXPERIENCE FOR PPO CLAIMS PAID DURING THE MONTH ENDED MM/DD/YY, RELATED TO THE PPO PERIOD THAT ENDED ON MM/DD/YY.


BASED ON THE ATTACHED INTERIM PPO RECONCILIATION, THE AMOUNT DUE FROM YOUR FACILITY IS \$7,694.58. BEGINNING WITH YOUR MM/DD/YY UPP CHECK, \$1,923.64 WILL BE DEDUCTED FROM YOUR NEXT FOUR UPP CHECKS ON THE PPO ALLOWANCE LINE.

IF YOU HAVE ANY QUESTIONS, CALL JOHN Q. PUBLIC, SENIOR REIMBURSEMENT SPECIALIST, AT (312) 653-XXXX.

ABC FACILITY
B.C. NO. 000
YTD FOR THE PERIOD MM/DD/YY THRU MM/DD/YY

TOTAL PPO ALLOWANCES	LESS: TOTAL PPO COLLECTIONS	AMOUNT DUE (FROM) TO BLUE CROSS	DIVIDED BY 4 WEEKS EQUALS UPP ADJUSTMENT (INCR)/DECR
\$164,129.08	\$156,434.50	7,694.58	1,923.64

Uniform Payment Program (UPP) Monthly Statement Sample/Field Explanations



ABC HOSPITAL
123 Main ST
Anytown IL 12345
ATTENTION: CONTROLLER

PAGE 1
CNT# 2

MM-DD-YY

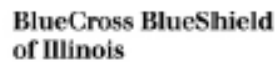
0000000000

<p>3</p> <p>CURRENT WEEKLY ADVANCE AMOUNT</p>	<p>4</p> <p>BALANCE FROM PREVIOUS MONTH</p>	<p>5</p> <p>TOTAL ADVANCES THIS MONTH</p>	<p>6</p> <p>TOTAL CLAIMS OFFSET THIS MONTH</p>	<p>7</p> <p>MONTH END BALANCE</p>
9,620,400.00	5,527,610.32	35,512,800.00	40,142,779.57	897,630.75
00-00-00				

<p>8</p> <p>DATE</p>	<p>9</p> <p>DAILY UPP VOUCHER NUMBER</p>	<p>DETAIL OF THIS MONTH'S ACTIVITY</p> <p>10</p> <p>UPP ADVANCES</p>	<p>11</p> <p>CLAIMS OFFSET</p>	<p>12</p> <p>WEEK END BALANCE</p>
NATIONAL PROVIDER IDENTIFIER(S) :		1295882561	1447423900	
04 05 13	03071095		1,411,064.31	
04 04 13	03072094		1,680,047.37	
04 03 13	03069093		1,706,545.39	
04 02 13	03070092		3,059,442.47	
04 01 13	03075091		2,065,870.32	
04 05 13	70122245	7,794,400.00		3,399,040.46
01 31 13	06117606		450.00	
02 28 13	06119266		1,231.00	
04 01 13	03075091		-62,353.92	
04 12 13	03069102		1,469,827.16	
04 11 13	03071101		1,366,246.14	
04 10 13	03071100		1,585,037.56	
04 09 13	03070099		2,550,869.61	
04 08 13	03071098		2,236,429.22	
04 12 13	70122479	9,049,000.00		3,300,303.69
04 19 13	03071109		1,885,708.22	
04 18 13	03075108		2,159,448.02	
04 17 13	03073107		1,996,726.47	
04 16 13	03074106		1,725,890.68	
04 15 13	03073105		1,685,343.67	
04 19 13	70122705	9,049,000.00		2,896,186.63
02 28 13	06119266		7,388.75	
03 28 13	06120917		446.98	
04 26 13	03074116		1,437,448.28	
04 25 13	03070115		1,913,232.08	
04 24 13	03073114		1,505,720.11	
04 23 13	03076113		1,411,333.20	
04 22 13	03078112		2,354,341.10	
04 26 13	70122934	9,620,400.00		3,886,676.13
04 30 13	03074120		2,082,212.52	
04 29 13	03071119		1,697,520.86	
04 30 13	06123144		-610,577.90	
04 29 13	06122850		-180,110.10	
13	Totals	35,512,800.00	40,142,779.57	



Billing and Reimbursement



CNT# 2

ABC HOSPITAL
123 Main ST
Anytown IL 12345
ATTENTION: CONTROLLER

MM-DD-YY

0000000000

CURRENT WEEKLY ADVANCE AMOUNT	EFFECTIVE DATE	BALANCE FROM PREVIOUS MONTH	TOTAL ADVANCES THIS MONTH	TOTAL CLAIMS OFFSET THIS MONTH	MONTH END BALANCE
9,620,400.00	00-00-00	5,527,610.32	35,512,800.00	40,142,779.57	897,630.75

DETAIL OF THIS MONTH'S ACTIVITY

	DAILY UPP VOUCHER			WEEK END
DATE	NUMBER	UPP ADVANCES	CLAIMS OFFSET	BALANCE
-----	-----	-----	-----	-----
	AVERAGE WEEKLY OFFSETS 3 MONTHS PERIOD ENDING 04-30-13			7,817,472.91
14	AVERAGE WEEKLY OFFSETS 6 MONTHS PERIOD ENDING 04-30-13			7,460,873.68
	AVERAGE WEEKLY OFFSETS 12 MONTHS PERIOD ENDING 04-30-13			7,341,107.49

Uniform Payment Program (UPP) Monthly Statement Sample/Field Explanations (Continued)

No.	Field Name	Description
1	Control Number (CNT #)	The number assigned for this statement.
2	Facility or Vendor Name & Address	The facility or vendor who rendered the service(s).
3	Current Weekly Advance Amount Effective Date	Advance payment. Net of contractual allowance or adjustments. The amount advanced for the week. The date (Friday) for the check advance.
4	Balance From Previous Month	The difference between the UPP advance and offsets (remittances) as of end of previous month.
5	Total Advances This Month	The total amount advanced for the month.
6	Total Claim Offset This Month	The sum of remittances and refunds to Blue Cross for the month.
7	Month End Balance	The Month End Balance is the Beginning Balance plus Advances minus Offsets.
8	Date	The date the daily voucher was issued.
9	Daily UPP Voucher Number	The daily non-payment voucher number and or BC 370 number.
10	UPP Advances	Weekly advance checks.
11	Claims Offset	Remittance Advice or BC 370.
12	Week End Balance	UPP advance plus or minus claim offsets.
13	Totals	Total UPP advance plus or minus claim offsets.
14	Average Weekly Offsets	Average weekly offsets (remittance and BC-370 amounts) used to calculate future UPP payments.

Refund Request Letter Sample



Phone Number

Production Date

CLAIM INFORMATION

UPP PROVIDER

STREET ADDRESS

CITY STATE 99999-9999

Patient's Name: ANN SMITH

Claim Number: 987654321980X

Group/ID No: P88888 – XOH888888888

Service Dates: To

Prov. Pat. No.: 01L1111111

Provider Name: UPP Provider

Reference No.:

Dear Provider Name:

We periodically review claim payments previously made. Occasionally an error is brought to our attention or is discovered during our review.

In reviewing the claims for this patient, we found that an overpayment was made because benefits were incorrectly coordinated with another health insurance carrier. The correct benefit payment for the services received by this patient is \$501.00. However, on MM/DD/YY, a payment of \$550.00 was issued to you. We regret that this error was made, and we request that you send the overpayment of \$49.00 to us.

To ensure that you are properly credited for the refund, we also request that you complete the attached form and mail it along with your check, made payable to Blue Cross and Blue Shield, in the enclosed postage-paid envelope.

Thank you in advance for your cooperation.

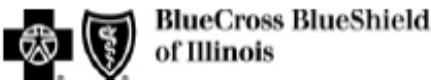
Sincerely,

Refund Recovery Unit

For more information on how this overpayment was determined and calculated, please call 1-800-972-8088. If your patient is a Federal Employee, please call 1-800-972-8382.

Call the number shown at the top of this letter to provide information or inquire about your refund.

Refund Request Follow-up Letter Sample



Phone Number

Production Date

CLAIM INFORMATION

UPP PROVIDER
STREET ADDRESS

CITY STATE 99999-9999

Patient's Name: ANN SMITH

Claim Number: 987654321980X

Group/ID No: P88888 – XOH88888888

Service Dates: FROM TO

Prov. Pat. No.: 01L1111111

Provider Name: UPP Provider

Reference No.:

Dear Provider Name:

If your refund check is in the mail, please disregard this letter.

In our letter of MMDDYY, we stated that an error was found in a previous payment made to you.

As previously explained, we found that on MMDDYY an overpayment of \$49.00, under check #03222222, was made to you because benefits were incorrectly coordinated with another health insurance carrier. The correct benefit payment for the services received by this patient should have been \$501.00. We regret that this error was made, and we request that you send the overpayment of \$49.00 to us.

To ensure that you are credited properly for the refund, we also request that you complete the attached form and mail it along with your check, made payable to Blue Cross and Blue Shield, in the enclosed postage-paid envelope.

Unless we hear from you within 30 days, we will have no alternative but to deduct the refund from your future claim payments.

Thank you in advance for your cooperation.

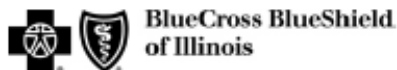
Sincerely,

Refund Recovery Unit

For more information on how this overpayment was determined and calculated, please call 1-800-972-8088. If your patient is a Federal Employee, please call 1-800-972-8382.

Call the number shown at the top of this letter to provide information or inquire about your refund.

Provider Claim Summary (PCS) Sample



PROVIDER CLAIM SUMMARY

DATE: MM/DD/YY

PROVIDER NUMBER: 0000009999

VOUCHER NUMBER: 03099999

TAX IDENTIFICATION NUMBER: 999999999

UPP PROVIDER
STREET ADDRESS
CITY STATE 99999 - 9999


MESSAGES WILL BE EXPLAINED ON PAGE 1

*****OUT-PATIENT

PATIENT: JANE DOE	PATIENT NO: AAA99999	ADMIT DATE	FROM DATE	END DATE
CLAIM NO: 0000123456789120C		MM/DD/YY	MM/DD/YY	MM/DD/YY
GROUP-SUB NO: H99999 XOH888888888			ICN NO:	

DAYS	ORIGIN	PROVIDER	BLUE CROSS	TOTAL AMOUNT	MANAGED CARE	TOTAL PATIENT	PROVIDER
TRT	CODE	CHARGE	PAID	PAID	DEDUCTION(S)	PORTION	LIABILITY
007	03	\$948.29	\$948.29	\$948.29	\$ 0.00	\$ 0.00	\$ 0.00

RECOUPMENTS TAKEN

PAT NAME	PAT ACCT NO	GROUP-SUBS NUMBER	CLAIM NUMBER	FROM/TO DATES	AMOUNT REASONS
SMITH	A	01L1111111 - P88888 - 888888888	987654321980X	MM/DD - MM/DD/YY	\$49.00 COORDINATION OF BENEFITS

PROVIDER CLAIMS AMOUNT SUMMARY

PROVIDER CHARGES:	\$948.29	I	PATIENT PORTION:	\$ 0.00
BLUE CROSS AMOUNT PD:	\$948.29	I	AMOUNT PAID:	\$948.29
MANAGED CARE DEDUCTION(S):	\$ 0.00	I	NUMBER OF CLAIMS:	1
PROVIDER LIABILITY:	\$ 0.00	I	RECOUPMENT AMOUNT:	\$49.00
			NET AMOUNT PAID TO PROVIDER:	\$899.29

ORIGIN CODE 01 IS HCMS ORIGIN CODE 02 IS SCMS ORIGIN CODE 03 IS BLUE CHIP

MESSAGES/REASONS:

NO MESSAGES FOR THIS DOCUMENT

H9999988888880000003099999