BlueCross BlueShield of Illinois

Medicaid Claim Filing Update

Effective beginning May 16, 2015, BCBSIL will implement system edits for Illinois Medicaid Professional and Institutional electronic claims (ANSI 837P and 837I transactions). Services must be appropriately billed on the 837P or 837I. **Claims submitted without the required claim data will be rejected.**

The following system edits will be implemented May 16, 2015:			
Required Information	**Medicaid Validation Rule**	**Claim Type(s)**	**Provider Responsibility**
Taxonomy Codes	Taxonomy Codes are required on all Medicaid claims. The HIPAA provider taxonomy code is a 10-character code and associated description that is used to identify each unique specialty for which a provider is qualified to provide health care services. The allowable taxonomy codes for Medicaid claims can be found on the Illinois Healthcare and Family Services Department (HFS) website at http://www.hfs.illinois.gov/assets/060607_app5.pdf A complete list of taxonomy codes can be found at http://www.wpc-edi.com/	Institutional and Professional	Providers must submit Taxonomy Codes on all Medicaid claims. **Professional:** Use the Taxonomy Code at the billing and rendering levels. (If there is no rendering provider, no taxonomy code is needed at the rendering level.) **Institutional:** Use the Taxonomy Code at the billing level **Where to include information on the 837:** **Billing:** Loop 2000A, PRV03 **Professional Claim Level:** Loop 2310B, PRV03 **Professional Line Level:** Loop 2420A, PRV03
Value Codes	Value Codes must be populated for covered and non-covered days on Institutional Inpatient (TOB- 011X), and Outpatient (TOB-013X, 014X) claims, where applicable. **Valid Values:** “80” = Covered Days “81” = Non-covered Days	Institutional	Providers must populate the Value Codes for covered and non-covered days on institutional inpatient and outpatient claims, where applicable. **837 Loop for inpatient and outpatient claims:** H102 HI*BE*XX
Condition Codes	Hospital inpatient claims require the entry of Condition Codes used to identify related conditions or events that may affect claim processing. Condition Codes C1 or C3 must be on the claim: **C1 = Approved as Billed** **C3 = Partial Approval**	Institutional	Providers must populate Condition Codes: C1 - Approved as Billed C3 - Partial Approval **837 Loop for inpatient claims:** H102 HI*BG*XX

The following edits will be implemented in mid- to late May 2015:			
Ambulatory Services Code	The Ambulatory Procedures Listing (APL) code billed on outpatient institutional claims must be from the Illinois Healthcare and Family Services Department (HFS) approved list of APLs. To view the APL list that was effective July 1, 2014, refer to the HFS website at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/070114APL1.pdf	Institutional	Providers must populate claims with codes from the HFS State approved APL list. For additional information pertaining to billing, refer to the following link: http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/5010.aspx
Provider NPI	The National Provider Identifier (NPI) is required on all electronic claims, including claims that are submitted with Payer ID MCDIL. The NPI that is submitted in the 837 transaction must be an NPI that has been reported to the Illinois Health Care and Family Services Department (HFS), prior to billing, to ensure that a crosswalk can be made from the provider's NPI to the HFS legacy number.	Institutional and Professional	Providers must register with the State of Illinois and validate their NPIs with the state MAP file prior to submitting a Medicaid claim. **Where to include information on the 837:** **Billing:** Loop 2010AA, NM109 **Professional Claim Level:** Loop 2310B, NM109 **Professional Line Level:** Loop 2420A, NM109