BlueCross BlueShield of Illinois

Outpatient and Inpatient Facilities - Tips on Submitting Claims for Medicaid Members

Below is information on filing outpatient and inpatient facility claims for members of our **Blue Cross Community Health Plans℠**. To help prevent delays in claim payments, refer to these solutions to common issues:

Facility Outpatient Claim Denials

HGD – Review taxonomy per Illinois Department of Healthcare and Family Services Rules
The claim was received with a service and taxonomy code combination that the provider is not attested for on date of service. Providers attested for HFS COS 027, 028 or 029 should make sure to submit claims with proper taxonomy code to align with the COS they are licensed for via their Illinois Medicaid Program Advanced Cloud Technology profile.

For more information on proper COS/taxonomy codes, refer to the IAMHP Comprehensive Billing Manual:

12h – Services not authorized (provider liable)
The claim was received with a service listed on our Medicaid prior authorization code grid and no authorization was located. This denial can be avoided when authorization is obtained prior to rendering service. A provider dispute can be filed if denial is received in error when a valid prior authorization was obtained for service.

Please refer to our prior authorization support materials for more details.

H37 – Please submit claim to primary insurance carrier
Our records indicate the member has other medical insurance coverage that is primary, and the claim was received without member's primary insurance coordination of benefits details. Corrected claims should be submitted reporting coordination of benefits details for processing as secondary by our plan.

A provider dispute can be filed if:

- The denial is received in error when the member doesn't have other primary insurance.
- The provider submits the primary carrier's EOB within 180 days from the paid date.

H97 – Invalid diagnosis for procedure
The service was reported with a diagnosis code that is not approved per clinical or regulatory policy**.** All services must be billed with a diagnosis that meets medical necessity as approved by national clinical and regulatory policy for payment by BCCHP℠. Verify diagnosis and clinical standards are met prior to rendering services to any member.

TF1 – Submitted after provider's filing limit
The claim was received after the 180-day timely filing limit. Claims are subject to 180-day timely filing limits from date of service. Please submit all claims on time for processing.

X28 – Claim billed with HFS non-covered revenue code

This is an informational denial as of April 1, 2024. Our system has been updated to allow HFS non-covered revenue code(s) to allow providers to represent a full claim experience for the member. These services remain nonpayable.

For more details, refer to the IAMHP Comprehensive Billing Manual.

W90 – Diagnosis code not allowed as principal diagnosis
Coded diagnosis should never be listed as principal diagnosis for a procedure. Review records for the more appropriate diagnosis and submit a corrected claim for processing.

HEM – Primary carrier payment exceeds HFS allowed
Information denial when coordination of benefits payment detail received on a BCCHP secondary claim exceeds HFS reimbursement.

HGA – Provider not attested for svc by HFS
The claim was received from a provider for a date of service or COS they aren't eligible for via IMPACT file. Review claim and IMPACT file for any discrepancy and correct if necessary.

H05 – Charges previously considered
A duplicate claim was received that was previously processed. Please note any changes to a previously adjudicated claim requires submission of a corrected/replacement claim. This must be completed via the corrected claim process.

Refer to the IAMHP Comprehensive Billing Manual for more information.

Facility Inpatient Claim Denials

12h – Services not authorized (provider liable)
The claim has denied due to no prior authorization for inpatient admission on file or the prior authorization request was denied. You may submit a provider service authorization dispute resolution request with all medical records attached.

Prior to July 1, 2025, all admission types require authorization. After July 1, 2025, emergency admission will allow two days without notification.

57H – Services denied at time auth/pre-cert req
The claim has denied because admission did not meet medical necessity during admission review. You may submit a provider service authorization dispute resolution request with all medical records attached.

HGT – ER+RB check billing rules IL medical
An inpatient bill type was received with 45x revenue code. However, HFS allows for the provider to be reimbursed for this service separately as an outpatient service and it should be billed via 131 claims for separate reimbursement.

For more information, refer to the IAMHP Comprehensive Billing Manual.

H33 – Please resubmit itemized bill

An inpatient claim was received on which all days were not approved. We require an itemized invoice to determine covered charges of approved days for reimbursement calculations. The itemized invoice can be submitted via our provider disputes process.

M77 – Bill type freq adm date from date match
An admit through a discharge bill type (111) was received with an admission date prior to the from date, which is not allowed on this type of bill. Review the claim's admission date and bill type for any needed update and resubmit via corrected claim for processing.

HDV – Freq. code 7 denied for TF
A corrected (frequency 7) claim was received past the timely filing limit. Be advised that corrected claims are also subject to a 180-day timely filing limit for date of discharge for inpatient claims. Any corrected claim received past the timely filing will deny with this explanation of benefits code.