



Blue Cross Community OptionsSM – Electronic Claim Submission Reminders

Payer ID – MCDIL

On Dec. 9, 2014, Blue Cross and Blue Shield of Illinois (BCBSIL) activated a new Payer ID – **MCDIL** – for electronic Blue Cross Community Options claims. Blue Cross Community Options include Blue Cross Community MMAI (Medicare-Medicaid Plan)SM, Blue Cross Community ICPSM, or Integrated Care Plan, and Blue Cross Community Family Health PlanSM (FHP). As we have announced in previous communications, all Blue Cross Community Options claims for MMAI, ICP or FHP members must be submitted using Payer ID MCDIL to help expedite processing.

While we are now moving into the last quarter of 2015, we continue to receive a significant volume of claims under the old Payer ID (00621). If you use a billing service or clearinghouse other than AvailityTM or Passport/Nebo Systems, it is important that you contact your vendor to ensure they are submitting your claims using the correct Payer ID (MCDIL). At some point, claims submitted under the incorrect payer ID may no longer be accepted, resulting in potential delays in payment. If you need assistance in converting to the new Payer ID, please contact your assigned Provider Network Consultant. We will work with you and your vendor to help ensure a smooth transition.

System Edits and Required Claim Data Elements

In addition to the new Payer ID, electronic claim system edits have been implemented to help ensure accurate adjudication and reporting to the state. The table below includes information on system edits and required data elements for services billed on electronic professional and institutional claims (837P and 837I transactions) for Blue Cross Community Options claims for MMAI, ICP or FHP members. If you have any questions regarding these edits or this notice, or if you need assistance navigating the Availity Web portal, please contact your assigned Provider Network Consultant.

System Edits	Medicaid Validation Rule	Claim Types	Claim Data
Taxonomy Codes	<p>Taxonomy Codes are required on all Medicaid claims. The HIPAA provider taxonomy code is a 10-character code used to help identify each unique specialty for which a provider is qualified to provide health care services.</p> <p>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</p> <p>A Health Care Provider Taxonomy Code Set listing can be found on the Washington Publishing Company (WPC) website at http://www.wpc-edi.com/reference/</p>	Institutional and Professional	<p>The taxonomy code is always required in the following 837 loops and segments:</p> <p>Billing Provider – Loop 2000A, PRV03</p> <p>The taxonomy code is required in the following 837 loops and segments when a Rendering Provider is submitted in these loops:</p> <p>Rendering Provider, Claim Level – Loop 2310B, PRV03 Rendering Provider, Line Level – Loop 2420A, PRV03</p>
Condition Code	<p>Hospital inpatient claims for Type of Bill 011 require the submission of Condition Codes used to identify related conditions or events relating to the bill that may affect processing.</p>	Institutional	<p>Condition Codes C1 or C3 must be included on the claim:</p> <p>C1 = Approved as Billed C3 = Partial Approval Loop 2300 HI Condition Code Segment</p>

System Edits	Medicaid Validation Rule	Claim Types	Claim Data
Ambulatory Services	The Ambulatory Procedures Listing (APL) code billed on outpatient institutional claims must be from the Illinois Healthcare and Family Services (HFS) approved list of APLs. To view the APL list that was effective July 1, 2014, refer the HFS website at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/070114APL_1.pdf	Institutional	Providers must populate claims with codes from the HFS State approved APL list. For additional information pertaining to billing, refer to the Medical Provider Handbooks on the HFS site at 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 837P and 837I transactions must be an NPI that has been reported to and registered with Illinois Healthcare and Family Services (HFS), prior to billing, to help ensure that a crosswalk can be made from the NPI to the HFS legacy number.* <i>*Providers must register with the State of Illinois and validate their NPIs with the Illinois Medical Assistance Program (MAP) file prior to submitting a Medicaid claim. For additional information, refer to the instructions for the Illinois MAP Provider Enrollment Application on the HFS site at http://www2.illinois.gov/hfs/sitecollectiondocuments/hfs2243i.pdf</i>	Institutional Professional	The appropriate NPI must be included in the following loops and segments: Billing – Loop 2010AA, NM109 Professional Claim Level – Loop 2310B, NM109 Professional Line Level – Loop 2420A, NM109

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