BlueCross BlueShield of Illinois

Medicaid Claims Handling for Medicaid Members

Blue Cross and Blue Shield (BCBS) Plans currently administer Medicaid programs in California, Delaware, Hawaii, Illinois, Indiana, Kentucky, Michigan, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Virginia and Wisconsin as a Managed Care Organization (MCO), providing comprehensive Medicaid benefits to the eligible population. Because Medicaid is a state-run program, requirements vary for each state, and thus each BCBS Plan. Medicaid members have limited out-of-state benefits, generally covering only emergent situations. In some cases, such as continuity of care, children attending college out-of-state, or a lack of specialists in the member's home state, a Medicaid member may receive care in another state, and generally the care requires benefit prior authorization.

Identifying Medicaid Members to Determine Eligibility and Benefits
BCBS Plan ID cards do not always indicate that a member has a Medicaid product. BCBS Plan ID cards for Medicaid members do not include the suitcase logo that you may have seen on most BCBS ID cards, but they do include a disclaimer on the back of the ID card providing information on benefit limitations. For members with such ID cards, you should obtain eligibility and benefit information and benefit prior authorization for services using the same tools you would use for other BCBS members.

- Submit an electronic eligibility inquiry through your preferred vendor portal, or by calling the BlueCard® Eligibility Line at 800-676-BLUE (2583).
- Obtain pre-service review using the Electronic Provider Access (EPA) tool.

Medicaid Reimbursement and Billing
Claims for all BCBS Medicaid members should be submitted to your local BCBS Plan. If you are contracted with your local BCBS Plan for Medicaid, your local Medicaid rates will only apply for Blue Cross and Blue Shield of Illinois (BCBSIL) members; they do not apply to out-of-state Medicaid members. When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member's home state. Please remember that billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations (42 CFR 447.15).

If you provide services that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

In some circumstances, a state Medicaid program will have an applicable copayment, deductible or coinsurance applied to the member's plan. You may only collect this amount from the member as applicable. Note that the coinsurance amount is based on the Medicaid fee schedule for that service.

Medicaid Billing Data Requirements
When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements.

Providers should always include their National Provider Identifier (NPI) on Medicaid claims, unless the provider is considered atypical. Providers should also bill using National Drug Codes (NDCs) on applicable claims. The data elements and other data elements that are important to submit on Medicaid claims, when applicable, are included below.

Applicable Medicaid claims submitted without these data elements will not be accepted:

- NDC
- Rendering Provider National Provider Identifier (NPI)
- Billing Provider NPI

Applicable Medicaid claims submitted without these data elements may be pended or not accepted until the required information is received:

- Billing Provider Second Address Line
- Billing Provider Middle Name or Initial
- Billing Provider Taxonomy Code
- Rendering Provider Taxonomy Code
- Service Laboratory or Facility Postal Zone or Zip Code
- Ambulance Transport Distance
- Service Laboratory Facility Name
- Service Laboratory or Facility State or Province Code
- Value Code Amount
- Value Code
- Condition Code
- Occurrence Codes and Date
- Occurrence Span Codes and Dates
- Referring Provider Identifier and Identification Code Qualifier
- Ordering Provider Identifier and Identification Code Qualifier
- Attending Provider NPI
- Operating Physician NPI
- Claim or Line Note Text
- Certification Condition Applies Indicator and Condition Indicator [Early and Periodic Screening Diagnosis and Treatment (EPSDT)]
- Service Facility Name and Location Information
- Ambulance Transport Information
- Ambulance Transport Reason Code
- Round Trip Purpose Description
- Stretcher Purpose Description

Medicaid Encounter Data Reporting
The data elements mentioned above need to be included on Medicaid claims, so that BCBS MCOs are able to comply with encounter data reporting requirements applicable in their respective state.

Provider Enrollment Requirements
Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement.

If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state's Medicaid program before submitting the claim. To view provider enrollment requirements for BCBS Medicaid states, please refer to the Medicaid Provider Enrollment Requirements, available in the Standards and Requirements/BlueCard Program section of our website at bcbsil.com/provider.

If you submit a claim without enrolling, your Medicaid claims will not be accepted and you will receive a message that the state where the member is enrolled in Medicaid requires that providers enroll in their Medicaid program before the Plan can pay the provider. To view provider enrollment requirements for the state where the member is enrolled, please visit http://www.bcbsil.com/pdf/standards/medicaid_provider_enrollment_requirements.pdf.

You will be required to enroll before the Medicaid claim can be processed and before you receive reimbursement.

Commonly Asked Questions

1. ***How do I submit Medicaid claims?***
   Medicaid claims should be submitted to your local BCBS Plan in the same manner as you submit claims for other BCBS members. You will also receive your payment in the same manner, although the payment amount will likely be different from your contracted rate, or different from the Medicaid rate in the state in which you practice.

2. ***How do I know that I am seeing a Medicaid member?***
   Members enrolled in a BCBS Medicaid product are issued BCBS Plan ID cards. BCBS Plan Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. BCBS Plan ID cards for Medicaid members:
   - Will not include a suitcase logo.
   - Will usually contain disclaimer language on the back of the ID card indicating benefit limitations for provider awareness, for example, “This member has limited benefits outside of BCBSIL. Providers should request eligibility/benefit information.”

3. Providers should always submit an eligibility inquiry if the Plan ID card has no suitcase logo and includes a disclaimer with benefit limitations, using the same tools available for BlueCard: Submit an electronic eligibility inquiry through your preferred vendor portal, or by calling the BlueCard Eligibility Line at 800-676-BLUE (2583).

4. Because Plan member ID cards will not always indicate that the member is enrolled in a Medicaid product, you should always obtain eligibility and benefit information. With an eligibility response, you should receive information on Medicaid coverage.

5. ***What amount should I expect to receive for members that reside outside of BCBSIL’s service area?***
   When billing for services rendered to an out-of-state Medicaid member, you will be reimbursed according to the member’s home state Medicaid fee schedule, which may or may not be equal to what you are accustomed to receiving for the same service in your state.

6. ***My state does not require me to include an NPI or NDC and many of the other data elements listed above on a Medicaid claim. Why do I have to include these codes?***
   Most state Medicaid programs require NPIs, NDCs and the additional data elements (when applicable) to be populated on claims submitted for Medicaid members for encounter data reporting purposes. To ensure compliance with state Medicaid requirements, providers who bill for Medicaid members should include these data elements on applicable BCBS Medicaid claims or the claims may be pended or not accepted.

7. ***I do not often see Medicaid members from another state. Why must I enroll as a Medicaid provider outside of my own state when billing for some Medicaid members in other states?***
   Many state Medicaid programs require providers to enroll before reimbursement may be provided by the Plan. If you do not enroll with the state where required, the claim could be denied.

8. ***Whom do I contact if I have questions?***
   If you have questions, please contact your BCBSIL Provider Network Consultant.

Exhibit 1 – Medicaid Billing Data Elements

Required Data Elements for Medicaid Claims *NOTE: Applicable Medicaid claims submitted without these data elements will not be accepted.*				
837 Reference	**837 Professional Electronic Claim[1] Data Element Reference**	**837 Institutional Electronic Claim[2] Data Element Reference**	**Professional Paper Claim (CMS-1500)[3] Item Reference**	**Institutional Paper Claim (UB-04)[4] Form Locator**
NDC	Loop 2410 LIN03	Loop 2410 LIN03	Item Number 24 Shaded Portion	Form Locator 43
Rendering Provider NPI	Loop 2310B NM109 unless overridden when reported in Loop 2420A NM109 ONLY when Rendering is different from Loop 2010AA Billing Provider	Loop 2310D NM109 unless overridden when reported in Loop 2420C NM109 ONLY when Rendering is different from Loop 2310A Attending Provider	Item Number 33A NPI or Item Number 24J (Unshaded) Rendering Provider ID	Form Locators 78-79 Form Locator 43 Line Level
Billing Provider NPI	Loop 2010AA NM109	Loop 2010AA NM109	Item Number 33A NPI	Form Locator 56

Other Data Elements for Medicaid Claims *NOTE: Applicable Medicaid claims submitted without these data elements may be pended or not accepted until the required information is received.*				
837 Reference	**837 Professional Electronic Claim[1] Data Element Reference**	**837 Institutional Electronic Claim[2] Data Element Reference**	**Professional Paper Claim (CMS-1500)[3] Item Reference**	**Institutional Paper Claim (UB-04)[4] Form Locator**
Billing Provider (Second) Address Line	Loop 2010AA N302	Loop 2010AA N302	Item Number 33 Billing Provider Information and Phone Number Line 2	Form Locator 1 Line 2
Billing Provider Middle Name or Initial	Loop 2010AA NM105	Loop 2010AA NM105	Item Number 33 Billing Provider Information and Phone Number Line 1	Form Locator 1 Line 1
(Billing) Provider Taxonomy Code	Loop 2000A PRV03	Loop 2000A PRV03	Item Number 33B Taxonomy Code preceeded by “ZZ” Qualifier	Form Locator 81
(Rendering) Provider Taxonomy Code	Loop 2310B PRV03 unless overridden when reported in Loop 2420A PRV03	Not applicable for institutional claim	Item Number 24I (Shaded Portion) = “ZZ” Qualifier Item Number 24J (Shaded Portion) = Taxonomy Code	Not applicable for institutional claim
(Service) Laboratory or Facility Postal Zone or Zip Code	Loop 2310C N403 unless overridden when reported in Loop 2420C N403	Loop 2310E N403	Item Number 32 Service Facility Location Information Line 3	Form Locator 1 Line 3
(Ambulance) Transport Distance	Loop 2300 CR106 unless overridden when reported in Loop 2400 CR106	Loop 2400 SV205 with applicable revenue code	Not reportable on 1500 form	Form Locator 42 with applicable revenue code
(Service) Laboratory Facility Name	Loop 2310C NM103 unless overridden when reported in Loop 2420C NM103	Loop 2310E NM103	Item Number 32 Service Facility Location Information Line 1	Form Locator 1 Line 1

Other Data Elements for Medicaid Claims ***NOTE: Applicable Medicaid claims submitted without these data elements may be pended or not accepted until the required information is received.***				
837 Reference	**837 Professional Electronic Claim[1] Data Element Reference**	**837 Institutional Electronic Claim[2] Data Element Reference**	**Professional Paper Claim (CMS-1500)[3] Item Reference**	**Institutional Paper Claim (UB-04)[4] Form Locator**
(Service) Laboratory or Facility State or Province Code	Loop 2310C N402 unless overridden when reported in Loop 2420C N402	Loop 2310E N402	Item Number 32 Service Facility Location Information Line 3	Form Locator 1 Line 3
Value Code Amount	Not applicable for professional claim	Loop 2300 HI in 5th position within the composite data element (Value Information HI) Up to 24 value codes may be reported with a corresponding amount	Not applicable for professional claim	Form Locators 39-41 Up to 12 value codes may be reported with a corresponding amount Form Locator 81 after above are exhausted
Value Code	Not applicable for professional claim	Loop 2300 HI in 2nd position within the composite data element (Value Information HI) Up to 24 value codes may be reported	Not applicable for professional claim	Form Locators 39-41 Up to 12 value codes may be reported Form Locator 81 after above are exhausted
Condition Code	Loop 2300 HI in 2nd position within the composite data element (Condition Information HI) Up to 24 condition codes may be reported	Loop 2300 HI in 2nd position within the composite data element (Condition Information HI) Up to 24 condition codes may be reported	Item Number 10d	Form Locators 18-28 Up to 11 condition codes may be reported Form Locator 81 after above are exhausted
Occurrence Codes and Dates	Not applicable for professional claim	Loop 2300 HI in 2nd and 4th positions within the composite data element (Occurrence Information HI) Up to 24 occurrence codes and associated dates may be reported	Not applicable for professional claim	Form Locators 31-34 Up to 8 occurrence codes and associated dates may be reported Form Locators 35-36 (FROM field) may be used when available Form Locator 81 after above are exhausted

Other Data Elements for Medicaid Claims

NOTE: Applicable Medicaid claims submitted without these data elements may be pended or not accepted until the required information is received.

837 Reference	837 Professional Electronic Claim[1] Data Element Reference	837 Institutional Electronic Claim[2] Data Element Reference	Professional Paper Claim (CMS-1500)[3] Item Reference	Institutional Paper Claim (UB-04)[4] Form Locator
Occurrence Span Codes and Dates	Not applicable for professional claim	Loop 2300 HI in 2nd and 4th positions within the composite data element (Occurrence Span Information HI) Up to 24 occurrence codes and associated dates may be reported	Not applicable for professional claim	Form Locators 35-36 Up to 4 occurrence span codes and associated dates may be reported Form Locator 81 after above are exhausted
Referring Provider Identifier and Identification Code Qualifier	Loop 2310A NM108/09 or REF01/02 unless overridden when reported in Loop 2420F NM108/09 or REF01/02	Loop 2310F NM108/09 or REF01/02 unless overridden when reported in Loop 2420D NM108/09 or REF01/02	Item Number 17A = Taxonomy Code preceeded by "ZZ" Qualifier 17B = NPI	Form Locators 78-79
Ordering Provider Identifier and Identification Code Qualifier	Loop 2420E NM108/09 or REF01/02 when a different from the service line Rendering Provider	Not applicable for institutional claim	Item Number 17A Other ID Number 17B = NPI	Not applicable for institutional claim
Attending Provider NPI	Not applicable for professional claim	Loop 2310A NM109	Not applicable for professional claim	Form Locator 76 Line 1
Operating Physician NPI	Not applicable for professional claim	Loop 2310B NM109 unless overridden when reported in Loop 2420A NM108/09	Not applicable for professional claim	Form Locator 77 Line 1
Claim or Line Note Text	Loop 2300 NTE02 unless overridden when reported in Loop 2400 NTE02 (Line Note NTE)	Loop 2300 NTE02	Item Number 19 Additional Claim Information	Form Locator 80
Certification Condition Applies Indicator and Condition Indicator [Early and Periodic Screening Diagnosis and Treatment (EPSDT)]	Loop 2300 CRC02, CRC03 (EPSDT Referral CRC) Loop 2300 CRC04 and CRC05 are used when additional conditions apply	Loop 2300 CRC02, CRC03 (EPSDT Referral CRC) Loop 2300 CRC04 and CRC05 are used when additional conditions apply	Item Number 24H EPSDT/Family Plan	Form Locators 18-28
Service Facility Name and Location Information	Not applicable for professional claim	Loop 2310E	Not applicable for professional claim	Form Locator 1

Other Data Elements for Medicaid Claims ***NOTE: Applicable Medicaid claims submitted without these data elements may be pended or not accepted until the required information is received.***				
837 Reference	**837 Professional Electronic Claim[1] Data Element Reference**	**837 Institutional Electronic Claim[2] Data Element Reference**	**Professional Paper Claim (CMS-1500)[3] Item Reference**	**Institutional Paper Claim (UB-04)[4] Form Locator**
Ambulance Transport Information	Loop 2300	Not applicable for institutional claim	Not reportable on 1500 form	Not applicable for institutional claim
Ambulance Transport Reason Code	CR104			
Round Trip Purpose Description	CR109			
Stretcher Purpose Description	CR110			

Checking eligibility and/or benefit information is not a guarantee of payment. Please note that the fact that a guideline is available for any given treatment, or that a service has been preauthorized, 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, please call the number on the member's ID card.

[1]ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837), May 2006, ASC X12N/005010X222, Type 1 Errata to Health Care Claim: Professional (837), June 2010, ASC X12N/005010X222A1 and Errata to Health Care Claim: Professional (837), January 2009, ASC X12N/005010X222E1.

[2]ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, Type 1 Errata to Health Care Claim: Institutional (837), October 2007, ASC X12N/005010X223A1, Type 1 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12N/005010X223A2 and Errata to Health Care Claim: Institutional (837), January 2009, ASC X12N/005010X223E1.

[3]National Uniform Claim Committee (NUCC). 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12. Version 2.0. July 2014.

[4] National Uniform Billing Committee (NUBC). Official UB-04 Data Specifications Manual 2015. Version 9.00. July 2014.