Updated: Nov. 2, 2021

Note: Plans not offering Medicaid products should distribute this document *with the implementation of National Programs Release 16.0 on April 17, 2016,* to explain that the new requirements are in effect..

The following information is provided to assist your Plan with provider education about BlueCard® and Inter-Plan business. While the information is believed to be accurate, you should review it carefully to make sure it is appropriate for use by your Plan. Please exercise caution when using the provider materials. Note that some areas of the materials may require customization with your Plan information, as indicated in parentheses and/or bold and that discretion should be used regarding necessary changes and/or modifications to this material. This information does not constitute, and is not intended as, legal or financial advice.

Medicaid Claims Handling for Medicaid Members

Blue Cross and Blue Shield 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 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 prior authorization for services using the same tools as you would for other BCBS members.

- Submit an eligibility inquiry by calling the BlueCard Eligibility Line at 800.676.BLUE.
- Submit an eligibility inquiry using BlueExchange.
- Obtain preservice 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. 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 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 (NDC) on applicable claims. These data elements and other data elements that are important to submit, when applicable, on Medicaid claims are included below.

Applicable Medicaid claims submitted without these data elements will be denied:

- National Drug Code
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)

Applicable Medicaid claims submitted without these data elements may be pended or denied 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
- Patient Weight

- 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 visit https://www.premera.com/wa/provider/bluecard-resources/.

If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive the following message from [insert Plan name] regarding the Medicaid provider enrollment requirements, "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 https://www.premera.com/wa/provider/bluecard-resources/

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

Commonly Asked Questions

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.

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 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 Washington state. Providers should request eligibility/benefit information.

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:

- BlueCard Eligibility Line
- BlueExchange

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.

What amount should I expect to receive for members that reside outside of Premera'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.

My state does not require me to include an NPI or NDC code 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 NPI and NDC codes 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 denied.

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.

Whom do I contact if I have questions?

If you have questions, please call Premera at 888-261-9562.

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Exhibit 1 – Medicaid Billing Data Elements

Required Data Elements for Medicaid Claims

NOTE: Applicable Medicaid claims submitted without these data elements will be denied.

837 Reference	837 Professional[1] Data Element Reference	837 Institutional[2] Data Element Reference	Professional Paper Claim Item Reference (CMS1500)[3]	Institutional Paper Claim Form Locator (UB04)[4]
National Drug Code	Loop 2410 LIN03	Loop 2410 LIN03	Item Number 24 Shaded Portion	Form Locator 43
Rendering Provider Identifier (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 denied until the required information is received.

837 Reference	837 Professional[1] Data Element Reference	837 Institutional[2] Data Element Reference	Professional Paper Claim Item Reference (CMS1500)[3]	Institutional Paper Claim Form Locator (UB04)[4]
Billing Provider (Second) Address Line	Loop 2010AA N302	Loop 2010AA N302	Item Number 33 Billing Provider Info & Ph # Line 2	Form Locator 1 Line 2

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Other Data Elements for Medicaid Claims

NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.

837 Reference	837 Professional[1] Data Element Reference	837 Institutional[2] Data Element Reference	Professional Paper Claim Item Reference (CMS1500)[3]	Institutional Paper Claim Form Locator (UB04)[4]
Billing Provider Middle Name or Initial	Loop 2010AA NM105	Loop 2010AA NM105	Item Number 33 Billing Provider Info & Ph # Line 1	Form Locator 1 Line 1
(Billing) Provider Taxonomy Code	Loop 2000A PRV03	Loop 2000A PRV03	Item Number 33B Other ID #	Form Locator 81
(Rendering) Provider Taxonomy Code	Loop 2310B PRV03 unless overridden when reported in Loop 2420A PRV03	Not applicable for institutional claim	24J Shaded when 24I Shaded = ZZ	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	Not applicable for institutional claim
(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 46 with applicable revenue code in Form Locator 42
(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	Not applicable for institutional claim
(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	Not applicable for institutional claim

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Other Data Elements for Medicaid Claims

NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.

837 Reference	837 Professional[1] Data Element Reference	837 Institutional[2] Data Element Reference	Professional Paper Claim Item Reference (CMS1500)[3]	Institutional Paper Claim Form Locator (UB04)[4]
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

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Other Data Elements for Medicaid Claims

NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.

837 Reference	837 Professional[1] Data Element Reference	837 Institutional[2] Data Element Reference	Professional Paper Claim Item Reference (CMS1500)[3]	Institutional Paper Claim Form Locator (UB04)[4]
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
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 Other ID# or 17b NPI #	Form Locators 78-79

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Other Data Elements for Medicaid Claims

NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.

837 Reference	837 Professional[1] Data Element Reference	837 Institutional[2] Data Element Reference	Professional Paper Claim Item Reference (CMS1500)[3]	Institutional Paper Claim Form Locator (UB04)[4]
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# or 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

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Other Data Elements for Medicaid Claims

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837 Reference	837 Professional[1] Data Element Reference	837 Institutional[2] Data Element Reference	Professional Paper Claim Item Reference (CMS1500)[3]	Institutional Paper Claim Form Locator (UB04)[4]
Service Facility Name and Location Information	Not applicable for professional claim	Loop 2310E	Not applicable for professional claim	Not applicable for institutional claim
Ambulance Transport Information Patient Weight Ambulance Transport Reason Code Round Trip Purpose Description Stretcher Purpose Description	Loop 2300 CR102 CR104 CR109 CR110	Not applicable for institutional claim	Not reportable on 1500 form	Not applicable for institutional claim

Endnotes

[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.