UB-04 CLAIM INSTRUCTIONS

UB-04 INPATIENT/OUTPATIENT BILLING INSTRUCTIONS

Printed claims and any associated documentation must be submitted as single-sided only.

The following is a locator by locator explanation of how to prepare a UB-04 claim form when the recipient has no other insurance or Medicare coverage. Please refer to the UB-04 Third-Party Liability Claim Instructions or UB-04 Medicare Crossover Claim Instructions to on complete a UB-04 claim when Medicaid is not the primary payer.

Mandatory locators must be completed. Conditionally mandatory locators must be completed if applicable. Please do not write or type above locator 1 of the claim form. Do not put social security numbers on the claim form.

LOCATOR 1   **PROVIDER NAME, ADDRESS & TELEPHONE NUMBER (MANDATORY)**
Enter the provider DBA Name as shown in the Organization Business Name on the SD MEDX enrollment record, address, city, state, zip code and telephone. Fax and country are optional.

LOCATOR 2   PAY TO NAME AND ADDRESS
Enter the pay to name, address, city, state, and zip code.

LOCATOR 3   PATIENT CONTROL NUMBER
Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

LOCATOR 4   **TYPE OF CLAIM (MANDATORY)**
Enter the code indicating the specific type of claim. The code must be determined within 24 hours of admission. The code may be updated as the patient meets the different criteria and cannot be changed once a physician has ordered discharge of the patient. For Long Term Care and Hospice please refer to those billing manuals.

HOSPITAL INPATIENT
111   Hospital Inpatient, Admission through Discharge
117   Hospital Inpatient, Replacement
118   Hospital Inpatient, Void

HOSPITAL OUTPATIENT
131   Hospital Outpatient, Admission through Discharge
137   Hospital Outpatient, Replacement
138   Hospital Outpatient, Void

OUTPATIENT HOSPITAL SURGICAL PROCEDURES
831   Outpatient Hospital Surgical Procedures, Admission through Discharge
837   Outpatient Hospital Surgical Procedures, Replacement
838   Outpatient Hospital Surgical Procedures, Void

LOCATOR 5   **FEDERAL TAX NUMBER (MANDATORY)**
The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

LOCATOR 6   **STATEMENT COVERS PERIOD (MANDATORY)**
Enter the beginning and ending service dates of the period included on this claim.

LOCATOR 7   UNLABELED FIELD
Leave Blank

LOCATOR 8   **PATIENT I.D. NUMBER AND NAME (MANDATORY)**
8a. Enter the patient's Medicaid ID number from the patient's South Dakota Medicaid card.
8b. Enter the patient's full name. Enter the name in the following format: last name, first name, middle initial. Example: Doe, Jane, S

LOCATOR 9   PATIENT ADDRESS
Optional

LOCATOR 10   PATIENT BIRTHDATE
If available, please enter in this format: MMDDYYYY Example: 08311988

LOCATOR 11   PATIENT SEX
Optional

LOCATOR 12   **ADMISSION/START OF CARE DATE (MANDATORY)**
Enter the date the patient was admitted for inpatient services.
Enter the date of service for an outpatient claim.

LOCATOR 13   **ADMISSION HOUR (CONDITIONALLY MANDATORY)**
Enter the hour during which the patient was admitted for inpatient or outpatient care. Mandatory for inpatient claims.

LOCATOR 14   **TYPE OF ADMISSION (MANDATORY)**
Enter the code indicating the priority of this admission.

Admission Type 1 - Indicates the Medicaid recipient was treated for a "true emergency".

Admission Type 2 - Indicates the Medicaid recipient was treated for urgent care. If marked urgent for a recipient in the Primary Care Provider (PCP)/Health Home (HH) Programs and the NPI of the PCP/HH is not in Block 78 or 79, Medicaid will reimburse the emergency room (450 revenue code) only. Any treatment (ancillary charge) is then the responsibility of the Medicaid recipient.

Admission Type 3 - Indicates the Medicaid recipient was treated for elective care. If there was an actual referral from the Primary Care Provider (PCP) then Block 78 or Block 79 must contain the recipient's PCP National Provider Identification (NPI) number.

Admission Type 4 – Indicates the Medicaid Recipients' age is 28 days or less.

LOCATOR 15 **SOURCE OF ADMISSION (CONDITIONALLY MANDATORY)**
This field is mandatory for all inpatient claims. All other claim types may leave this field blank.

Point of Origin for Admission or Visit
  0 Indian Health Services or 638 Contract Care

  1 Non-Health Care Facility Point of Origin

  2 Clinic or Physician's Office

  4 Transfer from a Hospital (Different Facility)

  5 Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or Assisted Living Facility (ALF)

  6 Transfer from another Health Care Facility

  8 Court/Law Enforcement

  9 Information not Available

  B Transfer from Another Home Health Agency

  D Transfer from one Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer

  E Transfer from Ambulatory Surgery Center

F   Transfer from a Hospice Facility

INVALID CODES:
3, 7, A, C, G-Z

<u>Code Structure for Newborn</u>

5   Born Inside this Hospital

6   Born Outside this Hospital

INVALID CODES:
1-4, 7-9

LOCATOR 16   **<u>DISCHARGE HOUR</u> (CONDITIONALLY MANDATORY)**
<u>This field is mandatory for all inpatient claims.</u> All other claim types may leave this field blank.

Enter the hour the patient was discharged from inpatient care.

LOCATOR 17   **<u>PATIENT STATUS</u> (MANDATORY)**
Please enter the appropriate discharge status.

Enter the code indicating the patient status as of the ending service date of the period covered on this bill. (See below the definitions of the only acceptable codes under South Dakota Medicaid.)

01   Discharged to home or self-care; jail or law enforcement; group home, foster care, & other residential care arrangements; Outpatient (OP) programs e.g. partial hospitalization, Outpatient chemical dependency programs; assisted living facilities that are not state designated (routine discharge)

02   Discharged/transferred to short-term general hospital for Inpatient Care

03   Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare certification in anticipation of covered skilled care. Do not use this for transfers to a non-Medicare certified area. For Swing Beds see Code 61 below

04   Discharged/transferred to an Intermediate Care Facility e.g. non-certified SNF beds, State designated Assisted Living Facilities

05   Discharged/transferred to a designated cancer center or children's hospital

06   Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care. Discharge/Transfer to home with written plan of care, foster care facility with home care & under home health agency with DME

07   Left against medical advice or discontinued care. Patients who leave before triage or seen by physician

09   Admitted as an inpatient (IP) to this hospital-only use on Medicare OP claims when services begin when those Medicare OP services are greater than 3 days prior to an admission

20   Expired - use only when the patient dies

21   Discharges or transfers to court/law enforcement; includes transfers to incarceration facilities such as jail, prison or other detention facilities.

30   Still a patient or expected to return for outpatient services-used when billing for LOA days or interim bills. It can be used for both IP or OP claims, for IP claims the claim needs to be greater than 60 days

40   Expired at home (Hospice claims only) used only on Medicare and TRICARE claims for hospice care

41   Expired in a medical facility (hospital, SNF, Intermediate Care Facility, or free-standing hospice) for hospice use only

42   Expired - place unknown -this is used only on Medicare and TRICARE claims for Hospice only

43   Discharged/transferred to a Federal hospital Department of Defense hospitals, VA hospitals, VA Psych unit or VA nursing facilities

50   Discharged/transferred to Hospice (home)-or alternative setting that is the patient's home such as nursing facility, and will receive in-home hospice services

51   Discharged/transferred to Hospice medical facility- patient went to an IP facility that is qualified and the patient is to receive the general IP hospice level of care or hospice respite care. Used also if the patient is discharged from an IP acute care hospital to remain in hospital under hospice care

61   Discharged/transferred within this institution to a hospital-based Medicare approved swing bed. This is also used when discharged from an acute care hospital to a Critical Access Hospital (CAH) swing bed

62   Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital

63   Discharged/transferred to a long-term care hospital

64   Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare. If the facility has some Medicare certified beds you should use patient status code 03 or 04 depending on the level of care the patient is receiving and if they are placed in a Medicare certified bed or not

65   Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

66   Discharged/transferred to a Critical Access Hospital (CAH)

69	Discharged/transferred to a designated disaster alternative care site
70	Discharged/transferred to another type of health care institution not defined elsewhere in the code list
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission
82	Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission
88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission
91	Discharged/transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission
93	Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission
95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

INVALID CODES:

08, 10-19, 22-29, 31-39, 44-49, 52-60, 67-68 these are all invalid codes which should not be used.

LOCATOR 18-28   <u>CONDITION CODES</u>

A code(s) used to identify conditions relating to this claim that may affect payer processing.

LOCATOR 29   ACCIDENT STATE
                    If applicable, the two-letter state abbreviation the accident occurred in.

LOCATOR 30   UNLABELED FIELD
                    Leave Blank

LOCATOR 31-34   OCCURRENCE CODES AND DATES
                    The code and associated date defining a significant event relating to this claim
                    that may affect payer processing.

LOCATOR 35-36   OCCURRENCE SPAN CODE AND DATES
                    A code and the related dates that identify an event that relates to the payment of
                    the claim.

LOCATOR 37   UNLABELED FIELD
                    Leave Blank

LOCATOR 38   RESPONSIBLE PARTY NAME AND ADDRESS
                    The name and address of the party responsible for the claim.

LOCATOR 39-41   **VALUE CODES AND AMOUNTS (CONDITIONALLY MANDATORY)**
                    A code structure to relate amounts or values to identified data elements
                    necessary to process this claim as qualified by the payer organization.

                    If applicable, newborn birth weight in grams is required to be entered on the
                    claim by entering value code "54" and the newborn's actual birth weight or weight
                    at time of admission for an extramural birth in the corresponding amount field.

                    All hospitals being reimbursed using the APC reimbursement methodology must
                    report any discounts received for medical equipment.

LOCATOR 42   **REVENUE CODE (MANDATORY)**
                    Enter the code which identifies the specific accommodation, ancillary service or
                    billing calculation. You can only use up to 250 revenue code lines per claim.

                    When billing a pharmacy revenue code 250-259 or 630-639 for any outpatient
                    claim then a procedure code and NDC must be reported. Failure to do so may
                    result in the claim denying or paying $0 for that line. Click here for the Noridian
                    Crosswalk.

LOCATOR 43   **REVENUE DESCRIPTION (MANDATORY)**
                    A narrative description of the related revenue categories should be included on
                    this claim. Abbreviations may be used.

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If using a drug-related procedure code, please enter the NDC in this format:
N4005913546ML5

Enter the N4 qualifier code followed by the 11-character NDC with no hyphens or spaces, the unit of measure <u>qualifier</u> and <u>quantity</u>. Valid HIPAA compliant unit of measure as follows and are case sensitive.

F2 = International Unit
GR = Gram
ME = Milligram
ML = Milliliter
UN = Unit

Please view additional guidance for <u>NDC billing here</u>.

LOCATOR 44   <u>**HCPCS/RATES**</u> **(CONDITIONALLY MANDATORY)**
HCPCS are only required when on applicable outpatient and pharmacy revenue codes. HCPCS are required on all APC claims.

Enter the accommodation rate for inpatient claims and the HCPCS applicable to ancillary service and outpatient claims.

Other Provider Preventable Conditions (OPPC) includes surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery. For any providers whom this applies, these OPPCs must be reported on the claims in any care setting in which they occur. The following procedure code modifiers must be billed as the primary modifier on the claim.

- Claim procedure code modifier: **PB** surgical or other invasive procedure on wrong patient
- Claim procedure code modifier: **PC** wrong surgery or the invasive procedure on patient
- Claim procedure code modifier: **PA** surgical or other invasive procedure on wrong body part

Non-OPPC modifier that must be billed primary modifier on the claim:
- Claim procedure code modifier: **GT** must be used with telemedicine revenue code 780 for inpatient claims

LOCATOR 45   <u>SERVICE DATE</u>
The date the indicated service was provided.

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LOCATOR 46 **UNITS OF SERVICE** **(MANDATORY)**

Enter the quantitative measure of services rendered by revenue code to or for the patient.

This must be a whole number. Partial numbers and decimals will not be accepted and may result in denials or incorrect payments. Billed units shall not exceed 999. Date spans where the units exceed 999 must be split into two separate lines with non-overlapping dates.

LOCATOR 47 **TOTAL CHARGES** **(MANDATORY)**

Enter total charges per line related to each revenue code. Total charges must equal the sum of the amounts listed per line. Total charges include both covered and non-covered charges.

LOCATOR 48 **NON - COVERED CHARGES** **(CONDITIONALLY MANDATORY)**

Only mandatory for revenue codes 253 and 637.

LOCATOR 49 UNLABELED FIELD

Leave blank.

LOCATOR 50 **PAYER IDENTIFICATION** **(MANDATORY)**

Enter the applicable three-digit payer code in the following order starting at locator 50A:

- 001 Medicare/Medi-gap/Advantage Plan (Refer to UB-04 Medicare Crossover Claim Instructions)
- 141 Primary Health Insurance
- 999 Medicaid
- 555 Recipient Cost Share

LOCATOR 51 HEALTH PLAN ID

Enter the 9-digit South Dakota Medicaid ID number.

LOCATOR 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR

A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

LOCATOR 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR

A code showing whether the provider has a signed form authorizing the third-party payer to pay the provider.

LOCATOR 54 PRIOR PAYMENTS – PAYERS

Leave blank

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LOCATOR 55   ESTIMATED AMOUNT DUE
Enter the total estimated recipient's responsibility prior to Medicaid submission. The same total amount entered on page 1 should be entered on all subsequent pages of multiple page claims.

LOCATOR 56   **NATIONAL PROVIDER NUMBER (NPI) (MANDATORY)**
Enter the provider's National Provider Identification (NPI) number.

LOCATOR 57   OTHER PROVIDER ID NUMBER
Leave Blank

LOCATOR 58   INSURED'S NAME
Leave Blank

LOCATOR 59   PATIENT'S RELATIONSHIP TO INSURED
Leave Blank

LOCATOR 60   **INSURED'S UNIQUE ID NUMBER (MANDATORY)**
The recipient identification number is the 9-digit number found on the South Dakota Medicaid Identification Card. The 3-digit generation number located behind the 9-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.

LOCATOR 61   INSURED GROUP NAME
Leave blank.

LOCATOR 62   INSURANCE GROUP NUMBER
Leave blank.

LOCATOR 63   TREATMENT AUTHORIZATION CODE
Required, if services must be prior authorized. Enter SD Medicaid prior authorization number here.

If prior authorization is not required, leave blank.

LOCATOR 64   DOCUMENT CONTROL NUMBER
Leave blank

LOCATOR 65   EMPLOYER NAME
Optional

LOCATOR 66   **DIAGNOSIS AND PROCEDURE CODE QUALIFIER (MANDATORY)**
The qualifier code that denotes the version of International Classification of Diseases (ICD) reported.

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LOCATOR 67	**PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)**

Enter diagnosis codes other than the principal diagnosis in form locators A-Q.

Principal Diagnosis Code is the ICD-10- code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

Other Diagnosis Codes is the ICD-10-diagnoses codes corresponding to additional conditions that co-exist at the time of admission, and/or develop subsequently and which have an effect on the treatment received or the length of stay.

When a Provider Preventable Condition (PPC) occurs in an inpatient setting, including observation, it must be indicated on the UB04 claim form with the appropriate ICD-10 diagnosis code in box 67. Any time one of the PPC ICD codes is entered it must be accompanied by the appropriate Present on Admission (POA) indicator in box 67. The POA indicators are listed in the table below. If a POA indicator is not entered following a PPC ICD code the claim will deny for reason – "Admission Information Is Invalid/Incomplete." When a POA indicator of N or U is entered the claim will pend for reason – "Review by Medical Consultant Required" for pricing to exclude the PPC.

UB04 locator 67 - Present on Admission (POA) Indicators

Y	Diagnosis was present at time of inpatient admission. Medicaid will pay the CC/MCC DRG/ or charges
N	Diagnosis was not present at time of inpatient admission. Medicaid will not pay the CC/MCC DRG/or charges
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. Medicaid will not pay the CC/MCC DRG/or charges
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. Medicaid will pay the CC/MCC DRG/or charges

LOCATOR 68	UNLABELED FIELD

Leave blank.

LOCATOR 69	**ADMITTING DIAGNOSIS (CONDITIONALLY MANDATORY)**

For Inpatient Claims Only:
Enter the diagnosis code provided at the time of admission as stated by the physician.

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LOCATOR 70   PATIENT'S REASON FOR VISIT
The diagnosis codes describing the patients' reason for visit at the time of outpatient registration.

LOCATOR 71   PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
The PPS code assigned to the claim to identify the DRG based on the grouper.

LOCATOR 72   EXTERNAL CAUSE OF INJURY CODE
Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect.

LOCATOR 73   UNLABELED FIELD
Leave blank.

LOCATOR 74   **PRINCIPAL AND OTHER PROCEDURE CODES AND DATE** (MANDATORY)
Enter the procedure code identifying the principal surgical or obstetrical procedure in locator 74. Enter other procedure codes in locators A-E. Date is required, if applicable.

LOCATOR 75   UNLABELED FIELD
Leave blank.

LOCATOR 76   **ATTENDING PHYSICIAN ID** (MANDATORY)
Enter the NPI and name of the practitioner who has overall responsibility for the patient's care and treatment reported in this claim.

Enter identifying qualifier and corresponding number when reporting a secondary identifier.

Please view NPI Requirements here.

LOCATOR 77   OPERATING PHYSICIAN ID
Enter the NPI and name of the individual with the primary responsibility for performing the surgical procedures reported in this claim.

Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 78-79   **OTHER PHYSICIAN ID** (MANDATORY)
Enter the NPI and name of the ordering, referring or rendering physician.

Primary qualifiers:
    DN- Referring Provider/Referring IHS Facility
    ZZ- Other Operating Physician

82- Rendering Physician

Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 80   <u>REMARKS</u>
Leave Blank.

LOCATOR 81   **TAXONOMY-CODE FIELD (MANDATORY)**
Use a B3 qualifier and all positions fully coded in the middle column; the right-hand column is left blank.

Example:

B	3	2	8	2	N	0	0	0	0	0	X											

QUICK ANSWERS

1. **I have a denial for a missing/invalid taxonomy code, what do I do?**

   Confirm your taxonomy code on your SD Medicaid enrollment record and compare it to the populated taxonomy code in 81A.

2. **How do I verify if I have a Type 1 or Type 2 NPI?**

   Visit https://npiregistry.cms.hhs.gov/.

3. **Do I need to enroll all my attending providers?**

   No. SD Medicaid has a streamlined enrollment process for ordering, referring, and attending physicians that may require no action on the part of the provider as submission of claims constitutes agreement to the SD Medicaid Provider Agreement. Provider NPIs in the ordering, referring, and attending physician fields on claims will be run-through SD's streamlined enrollment process without action by the provider. NPIs that are able to be confirmed as eligible provider types and meeting eligibility criteria will be deemed enrolled for purposes of that claim only. If providers receive a denial for ineligible attending, ordering, or referring physician, please refer to the Provider Enrollment and NPI Billing Chart to determine if the provider type is the appropriate type of provider to be listed before contacting the claims service unit for additional assistance.

4. **I have a denial because of private health insurance, what do I do.**

   Refer to the UB-04 Third Party Liability Claim Instructions.

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