MEDICAID PORTAL UB-04 SUBMISSION GUIDE

MEDICAID CLAIM SUBMISSION

Claim Submission via the Medicaid portal is a tool that allows the provider to submit institutional claims and attachments electronically to South Dakota Medicaid. This guide will outline Medicaid portal UB-04 Claim Submission variances. All South Dakota Medicaid Billing Instructions apply. Please review our billing manuals for specific claim guidance. For information on how to submit a Medicare Xover (Crossover Claim) please refer to the Medicare Xover (Crossover) Submission Guide.

MEDICAID CLAIM SUBMISSION PERMISSIONS

A Provider Administrator can add Claim Submission and/or Claim Submission View to the appropriate Provider User staff.
Open "User Maintenance", under the "Administration" tab.

Select the user you would like to add the permissions to.

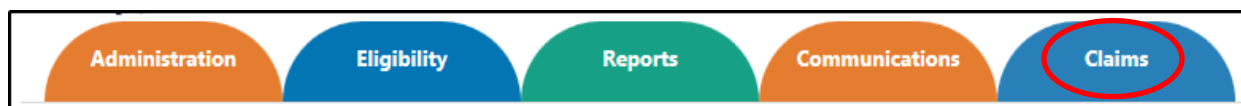Click "Update", then click "Next".

In the Permission Available select Claim Submission to allow the user to submit UB-04 claims and/or Claim Submission View which allows the user to view their submitted claims for the NPIs in their profile.

Once selected, click the arrow that is pointing to the right to move these options to the users'" Permissions Selected" and click "Update"

The user, if logged in will need to log out and log back in to see added permissions for the portal.
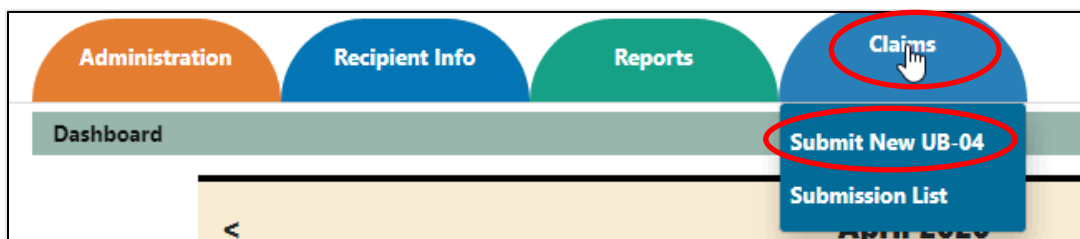
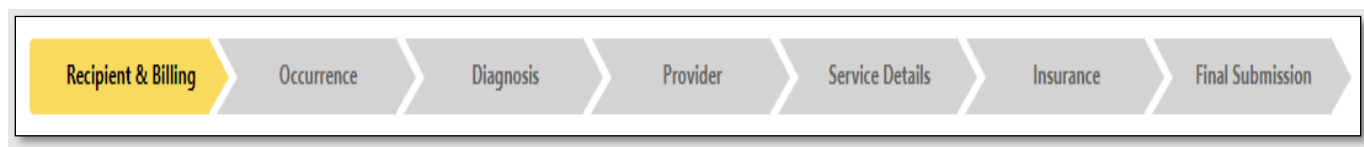Once permissions are updated the user will see the Claims tab.

SUBMIT A CLAIM

Under the "Claims" menu, hover on the claims tab with your pointer and select Submit New UB-04. The user may have additional permissions based on provider Billing NPI access.

For the Medicaid portal claim submission, the UB-04 Claim form has been split into seven sections.

Each section, upon clicking "NEXT" will be saved in the background. Once this step has been completed the tabs located across the top will turn green.

As a user, you will be able to navigate between the sections once the required information has been entered. The required information on the current screen must be completed before using this navigation function.

To go back, the user may click the green tabs (across the top) or use the "BACK" buttons.

Cancel a claim at any time by clicking "CANCEL"

Section 1: Recipient and Billing
Enter the recipient's ID Number and click "Verify". This will populate the recipient's name, DOB, Sex, and Address.

Enter the Patient Account number. (This corresponds to your Hospital Account/Record)

Select your Type of Bill from the drop-down menu.

> 111 - Hospital Inpatient, Admission through Discharge
> 131 - Hospital Outpatient, Admission through Discharge
> 211 - Long Term Care, Admission through Discharge
> 811 - Hospice, Non-Hospital Based
> 821 - Hospice, Hospital-Based
> 831 - Outpatient Hospital Surgical Procedures, Admission through Discharge

Enter the Billing Zip code+4, Billing NPI, and Billing Taxonomy for the facility.

*The user must have access to the Billing NPI before entering a claim.

Enter the statement covered period. The from date is entered first and to date is entered second. Enter these dates as the 2-digit month, 2-digit day, and 4-digit Year.

Continue by clicking the blue "NEXT" button (review and confirm information before moving on)

* Denotes a required field

Section 2: Occurrence

Incorporates the Admission, Discharge, Condition, Occurrence, and Value Codes for the UB-04 institutional claim.

Refer to the UB-04 Manuals that are specific to the Bill Type that you have chosen in Section 1. You may find these at https://dss.sd.gov/medicaid/providers/billingmanuals/. Different claim types have different required fields.

Enter the Admit Date in the 2-digit month, 2-digit day, and 4-digit Year.

Admit Hour, Type, Source, Discharge Hour, and Status are chosen from the drop-down menus. Enter the corresponding condition codes, if any, these are limited to a 2-byte format.

The Occurrence codes and Value codes are limited to a 2-byte format. South Dakota Medicaid accepted codes can be found in the corresponding claim manuals.

The Treatment Authorization code is where the provider may enter the Prior Authorization number for the services provided on this claim form.

Continue by clicking the blue "NEXT" button (review and confirm information before moving on)

* Denotes a required field

Section 3: Diagnosis

Diagnosis codes: The UB-04 Claims Submission application will only allow ICD-10 diagnosis codes and procedures. Do not use decimal points.

Check the box to the right of the field to indicate if the diagnosis is "Present on Admission".

Other Diagnosis and Present on Admission fields are to be entered from left to right. Only the top line is labeled for clarity.

All fields requiring dates can be chosen from the calendar or entered as 2-digit Month, 2-digit Day, and 4-digit Year.

Other surgical procedures are to be entered from left to right. Only the top line is labeled (A., B., C., etc.) for clarity.

Continue by clicking the blue "NEXT" button (review and confirm information before moving on)

* Denotes a required field

Section 4: Provider

In this section, the user will enter the corresponding physician's Servicing National Provider Identification (SNPI). The provider's Taxonomy is not required.

If entering a provider's NPI in locator 78 and/or 79, please choose the corresponding qualifier.

- ZZ-Other Operating
- 82-Rendering Provider

If you have the referring provider information available, choose "YES" and enter the referring provider's NPI information. "NO" may be selected if a referring provider is unknown at the time of the claim entry. This information can be entered oat a later date on INPATIENT claims only.

Please confirm all information before continuing by clicking the blue "NEXT" button.

* Denotes a required field

Section 5: Service Details

Revenue code, service date provided (depends on Type of Bill), Service Units/Days, HCPC, Modifiers, NDC information, and Charges are entered.

Revenue codes are limited to up to 250 revenue lines for entry on the portal. The place holder **"0"** will automatically be populated upon a 3-digit REV code entry.

If required by the type of bill, enter the corresponding service date information in a 2-digit Month, 2-digit Day, and 4-digit Year.

Enter corresponding service days or units to the HCPC or REV Code being billed.

Enter appropriate HCPC/CPT in locator 44. These are required to be 5 digits.

Modifiers may be entered as 2 digits and up to 4 modifiers per HCPC/REV code line.

NDC formatting is 11 digits without hyphens. Quantity follows a 0.000 format. Enter three digits after the decimal. If not, this will not allow for a continuation of claim entry. The NDC unit of measure can be chosen from the drop-down as follows:

- F2-International Unit
- GR-Gram
- ME-Milligram
- ML-Milliliter

- UN-Unit

Enter charges for the correlating REV code. Non-covered charges are not required, but if entered, please total all non-covered charges (locator 48), and click enter.

A REV code line will not be added until the green "+ADD" button is clicked. Once clicked the entered information will display in the Revenue line details.

The "RESET" button will reset the entry of the Rev Code entry, not the entire claim.

If corrections are needing to be made, the user may click "UPDATE" on the correlating Rev code line. If the line needs to be removed, click the icon. This will delete the REV Code line.

To add a second REV code line, and up to 250 lines, repeat the above steps until the claim is complete.

Please confirm all information before continuing by clicking the blue "NEXT" button.

* Denotes a required field

Section 6: Insurance

In this section, primary payor information can be entered.

Private Health Insurance (PHI) includes all payors that are considered a third-party liability.

Medicare and Medicare Advantage Plans are considered Standard Medicare plans.

Cost share is only reported in this section when a recipient is in a <u>Nursing Home, Swing Bed, or Hospice Care</u>, and has a cost share for those services. The Cost Share line is reported last after the Medicaid line.

Medicaid is what the provider is expecting for payment from the South Dakota Medicaid program. This payor type is required for all claim submissions.

Please choose the payor type from the drop-down menu:

- Medicare (Indicating Medicare on the 1st Line this will indicate a Medicare Crossover Claim)
- PHI
- Medicaid
- Cost Share

A maximum of three payor lines can be entered on a claim. If the claim has more than three payor lines, the prior payment must be combined into the first line.

All Private Health Insurance (PHI) (even if different payors) need to be combined if there are more than three payor lines; see examples below.

	Example #1	**Example #2**	**Example #3**
	Medicaid and PHI	Medicaid and 2 PHI	Medicaid, 2 PHI, and a Nursing Home Cost Share
Line #1	141	141	141 (Combine both PHI on one line)
Line #2	999	141	999
Line #3		999	555

The following fields are required when choosing a payor.

Prior Payment Amount: The total amount paid from the third liability plan/Medicare/Medicare Advantage Plan. ***Do not include contractual obligation which is found in locator 48.**

Example: If the recipient has 2 Private Health Insurances (PHI) add the total amounts paid.

* Denotes a required field

Insured's Unique ID/Payor: This is the recipient's ID number of the correlating coverage plan. (*required)

The fields below are requested but not required to have an entry

- Insured's Name: This is the Policyholder or Covered Member's name (not required)
- Insured Group Number: This is the group number associated with the policy coverage. (not required)
- Group Name: Name of the insurance plan (not required)
- Patient relation: choose from the drop-down the correct relation. (not required)
- Employer Name: If unknown, please type "unknown" (not required)

An insurance plan will not be added until the green "+ADD" button is clicked.

If corrections are needing to be made, the user may click "UPDATE" on the correlating insurance entry. If the line needs to be [trash icon] removed, click the icon. This will delete the insurance entry.

To add a second insurance plan, repeat the above steps, and continue until completed.

Please confirm all information before continuing by clicking the blue "NEXT" button.

Section 7: Final Submission

This final submission screen will give the provider a total of the claim charges entered as well as a revenue line count.

5 attachments in PDF, JPEG and/or GIF formats can be added to the claim. The attachments can be primary EOBs, notes, invoices, or documentation supporting the claim. Each attachment can be a max of 10 MB.

Review the attachments. If you cannot clearly read the attachment, SD Medicaid will not be able to either.

* Denotes a required field
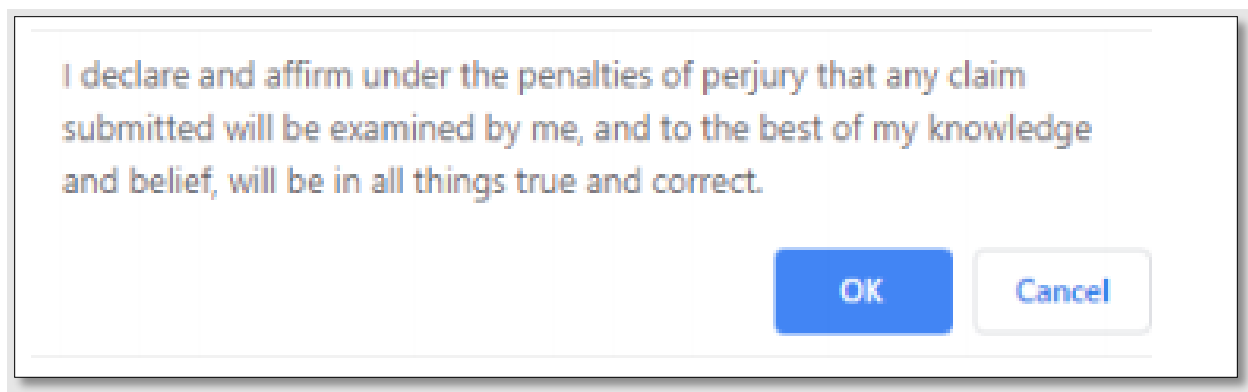
Upon clicking Submit, there will be a declaration box to "OK". The declaration takes place of the "Signature box."

Once you click "OK" the program will give you a claim number.
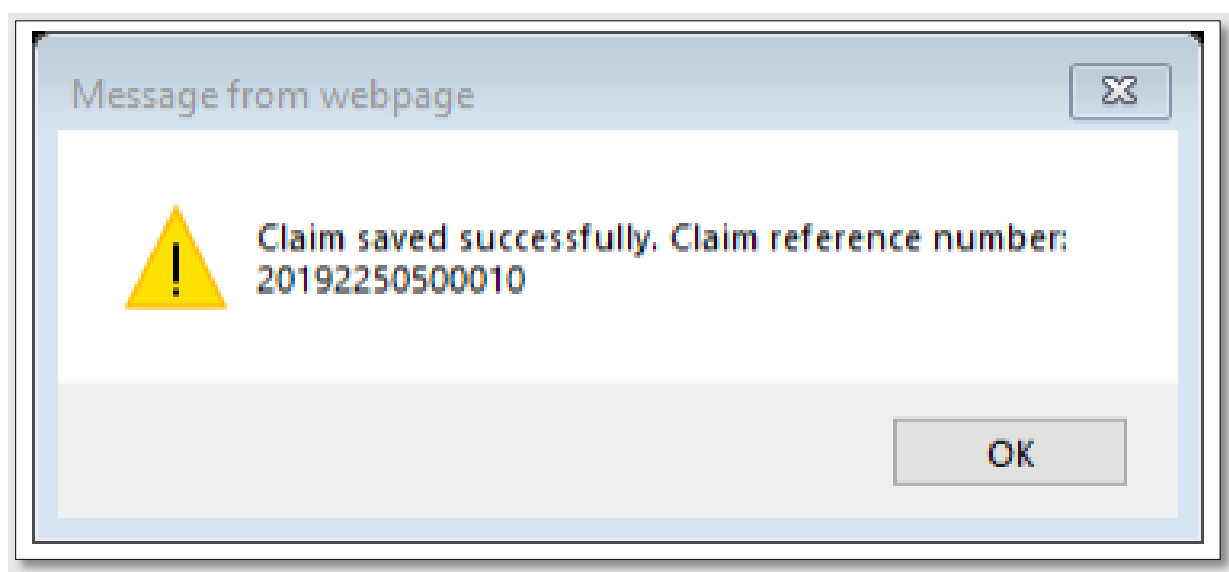
The claim reference number will show on the Submission List.

ADDITIONAL NOTES

Required Attachments

A claim submitted more than six months from the date of service, has third-party liability (TPL) or Medicare indicated, an attachment is required to submit.

SUBMISSION LIST

The Submission List will show the last 30 days of claims that have been saved and submitted. As a "Provider Administrator," you will be able to see all claims saved and submitted for the billing NPIs associated with your account. As a "Provider User," you will only be able to see claims you have worked on.

If a claim has not been submitted, you will have the option to "Update" the claim or "Delete" the claim. Once the claim is submitted the user may "View" the submitted claim within the portal. Another option is

for the user to download and/or print the submitted claim with the PDF icon. Once a claim is in a "Submitted" status it cannot be deleted or edited. If you need to change/update a claim you will need to follow the steps to "Adjust" or "Void" the claim, see below for instructions.

STATUS INFORMATION

In Process
Is a claim that has not been submitted to SD Medicaid. A claim in this status can be updated or deleted. Section 1 must be saved for the claim to appear on this list.

Submitted
This is a completed claim and has been submitted to SD Medicaid. Note, if the claim is submitted after 4:30pm CST, it will not be picked up by our system until after 7:30am CST the next business day. A claim in this status can only be viewed.

Accepted
This claim has been accepted by SD Medicaid and will be processed. A claim in this status can only be viewed.
NOTE: Claims submitted via the Medicaid Portal are considered electronic claims. If you have an EDI provider and you submit a claim on the portal that claim will also show up on your 837p.

Rejected
This claim was not accepted by SD Medicaid. This may happen if there is a server issue or other web-related issues. A claim in this status can only be viewed. A brand-new claim will need to be submitted.

SUBMISSION LIST MISC. INFO

Locked
Locked means someone is currently working on the claim. If you hover over the padlock or click update, it will give you the email of the person working on the claim. The record cannot be viewed until the person exits the claim, or in the case, they have walked away from their computer, 24 hours later.

Search Options
When using search, a Billing NPI is required.

Claim Specific Details
By clicking the "+" you can see claim specific details on the claim.

MEDICAID PORTAL UB-04 VOID GUIDE

Only claims submitted through the Medicaid portal can have an adjust/void completed. Only those with Administrative Permissions can complete a void through the Medicaid portal. If you need Administrative Permissions, you will need to have your current administrator give you access.

Claims are only allowed to be adjusted/voided within 30 days of submission through the portal.

- Claims over 30 days old are not allowed to be adjusted/voided through the portal.
- A claim can only be adjusted one time on the portal.
- You are not able to void an adjusted claim through the portal.
- Once a claim is voided no further changes are allowed.

MEDICAID PORTAL UB-04 VOID

To void a claim submitted through the Medicaid Portal, follow the steps listed below.

Begin by selecting the Submission List under the Claims tab.

Find the claim number you wish to void and select the Adjust/Void option

This will pop open another screen, select "Void Claim", and Submit.

After you click submit you will receive a claim confirmation.

The status of your claim from the submission list will also now reflect "Void Submitted"

MEDICAID PORTAL UB-04 ADJUSTMENT

To adjust a claim submitted through the Medicaid Portal, please follow the below steps.

Begin by selecting the Submission List under the Claims tab.

Find the claim number you wish to void and select the Adjust/Void option

	Claim Ref #	Billing NPI	Recip ID	Patient Account #	Submitter ID	Status	Action	Adjust/Void 🔒
+								
+								
+	20233170500010	012345678	000123456		DSS.CLAIMSPECIALISTS@state.sd.us	Accepted	👁 View 📄	Adjust/Void
+	20233170500000	012345678	000123456		DSS.CLAIMSPECIALISTS@state.sd.us	Accepted	👁 View 📄	Adjust/Void

<< < 1 > >> Go to page: 1 ▾ Row count: 10 ▾   Showing 1-4 of 4

This will pop open another screen, select "Adjust Claim", and Submit.

Adjust/Void

✱ Please select one of the following.

◯ Adjust Claim

◯ Void Claim

✔Submit   ✖ Exit

After you click submit, the claim will auto-populate. Fields that can be adjusted will open to make changes. In the example below, diagnosis E11.9 was added to the claim. Navigate through the various screens of the claim by using the "Previous" and "Next" buttons.

When you are done making changes, navigate through to the last page **"Final Submission"** to submit the adjusted claim.

The claim has not been submitted successfully without receiving the message below.
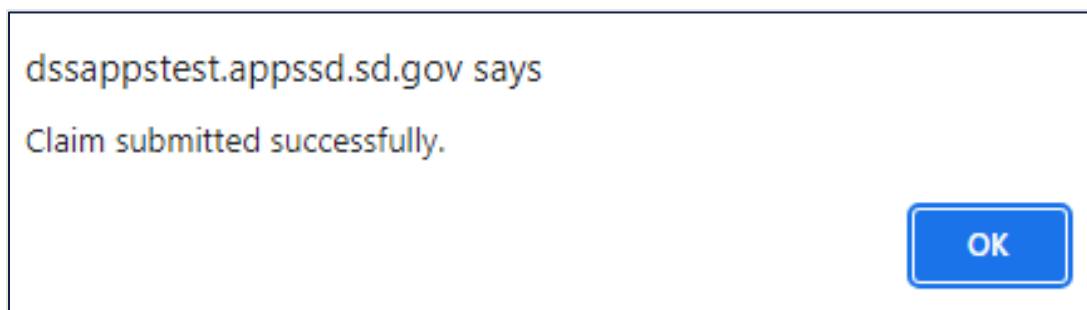
The status of the claim from the submission list will also now reflect "Adj/Submitted"

QUICK ANSWERS

1. **Why are not all fields required for claims submission?**

   Online claims submission is not for a specific provider but for multiple providers. Required information varies based on services provided or on the restrictions of the provider enrollment. Please follow the same requirements that are required on a paper claim submission. https://dss.sd.gov/medicaid/providers/billingmanuals/

2. **Can I scan in a claim and have it auto-populate fields?**

   No. All claim information will be entered manually.

3. **Can I edit auto-populated information?**

   This is currently not available.

4. **Am I allowed to see what others in my department have been working on for the provider's NPI?**

   The Provider Administrator is the only user who can see the provider's online claims submission history. A Medicaid Portal User is limited to their individual log in with the combination of billing and servicing provider's NPI assignments.

5. **Can I correct a claim once I have clicked the submit button?**

   Yes, a claim can be adjusted one time after the initial submission. Find the claim on the claims submission listing and follow the steps in the guide on how to complete a claim adjustment.

6. **Can I save a claim and come back to it later?**

Yes, although a "saved" non-submitted claim will only be on the user's claim submission list for a maximum of 30 days.

7. **I have a rejected claim, now what?**

    Please re-enter and submit a new claim. If the claim is again rejected, please contact DSSonlineportal@state.sd.us; Please provide a screen shot of the rejected claim.

8. **Can I use the PDF of my claim to send as a paper claim?**

    No, the PDF is for your records only and is not a valid claim form for submission.

9. **Can I use adjust a claim more than one time?**

    No, the Medicaid portal allows for one claim adjustment.

10. **Can I update a voided claim?**

    No, once a claim is voided it can no longer be used.

11. **How long can I view a claim submitted on the Medicaid portal?**

    A claim can be viewed in the submission listing for 30 days; however, if you have the claim reference # you are able to search and view the claim for 6 months.