

PORTAL UB-04 SUBMISSION GUIDE

CLAIM SUBMISSION

Claim Submission via the online portal is a tool that allows the provider to submit an institutional claim and attachments electronically to South Dakota Medicaid. This guide will outline Portal UB-04 Claim Submission variances. All South Dakota Medicaid Billing Instructions apply. Please review our [billing manuals](#) for specific claim guidance.

CLAIM SUBMISSION PERMISSIONS

A Provider Administrator can add UB-04 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 CMS 1500 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 selected users' permissions and click "Update"

The screenshot shows a user interface for managing permissions. It is divided into two main sections: 'Permissions Available' on the left and 'Permissions Selected' on the right. Both sections have a 'Select All' checkbox at the top. The 'Permissions Available' section contains a list of permissions with checkboxes: Negative Balance Report, PCP - Case Load, PCP - Claims Paid, PCP - RA, Service Limits, Claim Submission, Institutional Claim Submission (checked), and Claim Submission View (checked). There are two blue arrows between the sections, one pointing right and one pointing left. The 'Permissions Selected' section is currently empty.

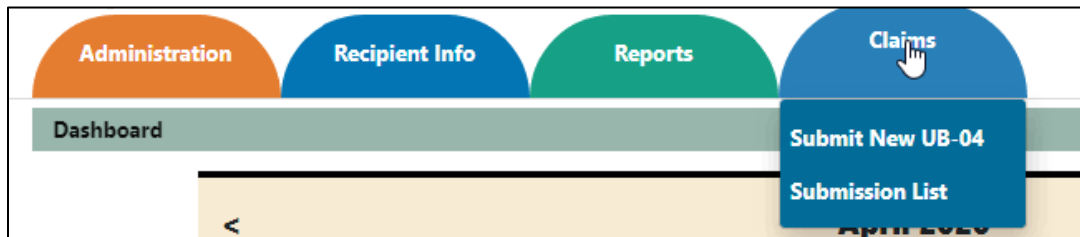
Once permissions are updated the user will see the Additional option on the claims tab or will see the claims tab if the user did not have permission to submit before this permission add. The user, if logged in will need to log out and log back in to see added permissions for the portal.

A user will need to have access to the Billing NPI to submit claims.

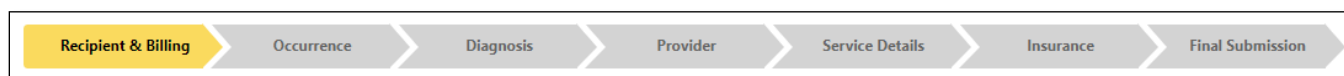


SUBMIT A CLAIM

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 online claim submission, the UB-04 Claim form has been split into seven different sections for ease of entry.



Each section, upon clicking “NEXT” will be saved in the background. Once this step has been completed the tabs will turn green.

As a user, you will be able to navigate between the sections once the required information has been entered. You will need to enter in the required information on the current screen before using this navigation functions.

If needing to go back, the user may click the green tabs or “BACK” buttons.

If at any time you need to cancel your claim, the user may click “CANCEL” the claim will not be saved.

Section 1: Recipient and Billing

Enter the recipient’s ID Number and click “Verify”. This action will populate the recipient’s information in the following fields: Patient’s Name, DOB, Sex, Address.

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

Choose 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. 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.

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

* Denotes a required field

* Denotes required field. A record can only be saved if all required fields have been completed.
This page's information will be saved when clicking the next button.

Recipient & Billing Occurrence Diagnosis Provider Service Details Insurance Final Submission

60. Insured's I.D. Number *

8b. Patient Name 10. Patient's Birth Date 11. Patient's Sex

9. Patient's Address

3a. Patient Account No. * 4. Type of Bill *

1. Billing Zip Code * 56. Billing NPI * 81a. Billing Taxonomy *

6. Statement Covers Period *

Section 2: Occurrence

This section also 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 [here](#). For certain types of bill claims, the required fields will change based on the requirements.

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 all 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.

The document Control Number is for future development. A void or adjustment of a claim must occur electronically or via a paper claim.

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

* Denotes a required field

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This page's information will be saved when clicking the next button.

Recipient & Billing	Occurrence	Diagnosis	Provider	Service Details	Insurance	Final Submission					
12. Admit Date MM/DD/YYYY		13. Admit Hour Select									
14. Admit Type * 1		15. Admit Source Select									
16. Discharge Hour Select		17. Discharge Status Select									
Condition Codes	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.
Occurrence Code and Date	31a	MM/DD/YYYY	31b	MM/DD/YYYY	32a	MM/DD/YYYY	32b	MM/DD/YYYY			
	33a	MM/DD/YYYY	33b	MM/DD/YYYY	34a	MM/DD/YYYY	34b	MM/DD/YYYY			
Occurrence Code and Date Span	35a	MM/DD/YYYY	MM/DD/YYYY		35b	MM/DD/YYYY	MM/DD/YYYY				
	36a	MM/DD/YYYY	MM/DD/YYYY		36b	MM/DD/YYYY	MM/DD/YYYY				
Value Code and Amount	39a.		39b.		39c.		39d.				
	40a.		40b.		40c.		40d.				
	41a.		41b.		41c.		41d.				
63. Treatment Authorization Code	Document Control Number		For Future Development								

← Previous ✕ Cancel → Next

Section 3: Diagnosis

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

Please make sure to 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 are 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.

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

* Denotes a required field

* Denotes required field. A record can only be saved if all required fields have been completed.
This page's information will be saved when clicking the next button.

Recipient & Billing | Occurrence | **Diagnosis** | Provider | Service Details | Insurance | Final Submission

Check the box if Present on Admission

66. Principal Diagnosis and Present On Admission * 69. Admitting Diagnosis

Other Diagnosis and Present on Admission

	A.	B.	C.	D.	E.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

70. Patient Reason Diagnosis

71. PPS Code

72. ECI

73. Reserved For Future Developme

74. Principal Surgical Procedure and Date MM/DD/YYYY

Other Surgical Procedure and Date

	A.	B.	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	MM/DD/YYYY <input type="text"/>	<input type="checkbox"/>	MM/DD/YYYY <input type="text"/>
<input type="text"/>	MM/DD/YYYY <input type="text"/>	<input type="text"/>	MM/DD/YYYY <input type="text"/>
<input type="checkbox"/>	MM/DD/YYYY <input type="text"/>	<input type="checkbox"/>	MM/DD/YYYY <input type="text"/>
<input type="text"/>	MM/DD/YYYY <input type="text"/>	<input type="text"/>	MM/DD/YYYY <input type="text"/>
<input type="checkbox"/>	MM/DD/YYYY <input type="text"/>	<input type="checkbox"/>	MM/DD/YYYY <input type="text"/>

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, please chose "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 may be entered at a later date on INPATIENT claims only.

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

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This page's information will be saved when clicking the next button.

Recipient & Billing → Occurrence → Diagnosis → **Provider** → Service Details → Insurance → Final Submission

76. Attending Provider NPI*

77. Operating Provider NPI

78. Other Provider NPI Qualifier

79. Other Provider NPI Qualifier

Referring Provider Available YES NO

Referring Provider NPI

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.

NDCs follow the standard 11-digit NDC codes without hyphens. Quantity follows a 0.000 format. Please make sure to 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 the all non-covered charges and 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.


* Denotes required field. A record can only be saved if all required fields have been completed.
This page's information will be saved when clicking the next button.

Recipient & Billing Occurrence Diagnosis Provider Service Details Insurance Final Submission

42. Rev Code * 45. Service Date 46. Service Units/Days *
 44. HCPC Modifier
 NDC NDC Quantity NDC Unit of Measure
 43. Rev Desc 47. Charges * 48. Non-Covered Charges

Revenue Line Details										
Rev Line	Rev Code	Service Date	Units /Days	HCPCS	Modifier	NDC	Description	Charges	Non-Covered	Action
No data available!										

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 and continue until completed.

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

* Denotes a required field

* Denotes required field. A record can only be saved if all required fields have been completed.
This page's information will be saved when clicking the next button.

Recipient & Billing Occurrence Diagnosis Provider Service Details Insurance Final Submission

42. Rev Code * 45. Service Date 46. Service Units/Days *

44. HCPC Modifier

NDC NDC Quantity NDC Unit of Measure

43. Rev Desc 47. Charges * 48. Non-Covered Charges

Revenue Line Details										
Rev Line	Rev Code	Service Date	Units /Days	HCPCS	Modifier	NDC	Description	Charges	Non-Covered	Action
1	0360	07/23/2020	1	99238			General	\$259.00	\$0.00	<input type="button" value="Update"/> <input type="button" value="Delete"/>

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 the recipient's share of the cost of the visit, this would be due from the patient based on eligibility screen or services provided.

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
- PHI
- Cost Share
- Medicaid

If you have more than one type of payor, please combine the payor information under one entry. All of the following fields are required when choosing a payor.

Prior Payment Amount: The total amount paid/adjusted from the third liability plan or Medicare plan

Example: If the recipient has 2 Private Health Insurances (PHI) add the total amounts paid, contractual/network savings together.

* Denotes required field. A record can only be saved if all required fields have been completed.
This page's information will be saved when clicking the next button.

Recipient & Billing → Occurrence → Diagnosis → Provider → Service Details → **Insurance** → Final Submission

29. Accident State

50. Payer* 51. Health Plan ID

53. Assignment of Benefits Certification Ind 54. Prior Payment Amount

60. Insured's Unique ID 58. Insured's Name

62. Insured Group Number 61. Group Name

59. Patient Relation 65. Employer Name

52. Release Info Certification Indicator 55. Estimated Amount Due

Payer Details									
Payer	Prior Payment	Estimated Amount	Insured Unique ID	Insured's Name	Group Number	Group Name	Patient Relation	Employer Delete Name	
<< < 1 > >>	Go to page:	1	Row count:	5					Showing 1-1 of 1

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

Insured's Name: This is the Policyholder or Covered Member's name (not a required field)


Insured Group Number: This is the group number associated with the policy coverage. (not a required field)

Group Name: Name of the insurance plan (not a required field)

Patient relation: choose from the drop-down the correct relation. (not a required field)

Employer Name: If unknown, please type "unknown" (not a required field)

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 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.

* Denotes a required field

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.

You may add up to 5 attachments in either a PDF, JPEG, and/or GIF formats. These attachments could be primary EOBs, notes, invoices, or documentation supporting your claim. Each attachment can be a max of 10 MB. Please review your attachments. If you are not able to read the document attached, SD Medicaid will encounter the same difficulty.

* Denotes required field. A record can only be saved if all required fields have been completed.
This page's information will be saved when clicking the next button.

Recipient & Billing > Occurrence > Diagnosis > Provider > Service Details > Insurance > Final Submission

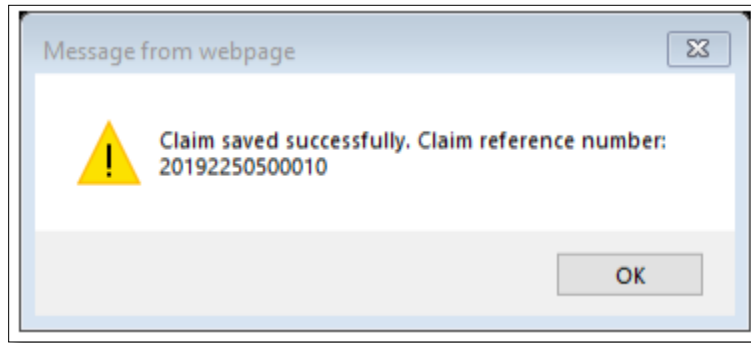
Total Charges	<input type="text" value="3000.00"/>	Revenue Line Count	<input type="text" value="1"/>
80. Remark	<input type="text" value="For Future Development"/>		

Add Attachments:
Up to 5 attachments with a max of 10 mb each can be uploaded with the following formats: PDF, JPEG and GIF.

Upon hitting Submit, there will be a declaration box to “OK”. The declaration takes place of the “Signature box”

I declare and affirm under the penalties of perjury that any claim submitted will be examined by me, and to the best of my knowledge and belief, will be in all things true and correct.

Once you hit “OK” the program will give you a claim number.



The claim reference number will also be on the Submission List.

ADDITIONAL NOTES

Items needing documentation attached

If a claim is past timely filing (6 months), has TPL or Medicare indicated, an attachment will be necessary 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.

STATUS INFORMATION

In Process

This is a partial entered claim that has not been submitted to SD Medicaid. A claim in this status can be updated or deleted. Note, at minimum Section 1 must be saved in order to have the claim 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 Provider 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 able to be 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

As a provider admin, you may see that the “in-process” claim is locked. This means that someone is currently working on the claim. If you hover over the padlock or hit 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

If you are using any of the search options available to narrow down your results you will need to enter a Billing NPI.

Claim Specific Details

By clicking the “+” you will be able to see claim specific details on the claim.

QUICK ANSWERS

1. Why are not all fields required for claims submission?
 - a. Online claims submission is not for a specific provider but 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. Am I able to scan in a claim and have it auto-populate fields?
 - a. No, all data will need to be typed in for every claim submitted.
 3. Am I allowed to submit an adjustment claim or void claims?
 - a. This is currently not an available function but has been added for development at a later date.
 4. Am I allowed to see what others in my department have been working on for the provider's NPI?
 - a. The Provider Administrator is the only user who can see the provider's online claims submission history. A Portal User is limited to their login with the combination of billing and servicing provider's NPI assignments.
 5. Am I able to correct a claim once I have clicked the submit button?
 - a. No, once the submit button is clicked, your claim has been submitted. Please review the claims submission list for more details.
 6. Am I able to save and come back to a claim?
 - a. Yes, although a "saved" non-submitted claim will only be on the user's claim submission list for a maximum of 30 days.
-