UB-04 LONG-TERM CARE CLAIM INSTRUCTIONS

OVERVIEW

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 in a long-term care facility. Please refer to the other UB-04 billing type instructions to complete a UB-04 claim if the recipient has not elected long-term care.

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 South Dakota Medicaid 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 BILL (MANDATORY)**
Enter the code indicating the specific type of bill. The code must be determined within 24 hours of admission. For other billing types please refer to the appropriate manual.

LONG TERM CARE

211	Admission through Discharge
212	Interim First Claim
213	Interim Continuing Claim
217	Adjustment
218	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. Statement cover dates are by calendar month.

LOCATOR 7 — UNLABELD 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 recipient's 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 of admission to long-term care.

LOCATOR 13 **ADMISSION HOUR (MANDATORY)**
Enter the hour during which the patient was admitted for long-term care.

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

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.

LOCATOR 15 **SOURCE OF ADMISSION (CONDITIONALLY MANDATORY)**

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

Code Structure for Newborn

5 Born Inside this Hospital

6 Born Outside this Hospital

INVALID CODES:
1-4, and 7-9

LOCATOR 16 **DISCHARGE HOUR (CONDITIONALLY MANDATORY)**
Mandatory only when patient is discharged.
Enter the hour the patient was discharged from long-term care.

LOCATOR 17 **PATIENT STATUS (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 claim. (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 when the patient dies and there is not a more applicable patient status code)

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, and 67-68 these are all invalid codes which should not be used.

LOCATOR 18-28 CONDITION CODES
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.

Occurrence code:
50 Medicare Pay Date
51 Medicare Denial Date
53 Late Bill Override Date

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.

Occurrence Span Code:
70 Hospitalization
74 Therapeutic Leave Days
77 Provider Liability Period

LOCATOR 37 UNLABELED FIELD
Leave Blank

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

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

LOCATOR 42 **REVENUE CODE (MANDATORY)**
Enter the code which identifies the specific accommodation or billing calculation. Ancillary services must be billed on a different claim form using outpatient bill type. You can only use up to 250 lines per claim. All like revenues codes must be billed on the same revenue line.

The following REV Codes are approved for Long-Term Care Facilities:

118	Traumatic brain injury*
119	Private
129	Semi-private
183	Therapeutic leave days – maximum of 15 units
185	Hospital reserve bed days – maximum of 5 units
189	Medicare days – pay at zero
279	Wound vac*
291	Specialty bed/mattress service*
412	Ventilator*
559	Other skilled Nursing (chronic complex medical needs add-on) *
780	Telemedicine (For Originate Site Only)
919	Extreme behavior*
001	Grand total on last line

*Only billable with prior authorization from APRT (recipients over age of 21) or SD Medicaid (recipients under 21).

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

LOCATOR 44 **HCPCS/RATES (CONDITIONALLY MANDATORY)**
Enter HCPCS when mandatory in conjunction with applicable revenue code.

LOCATOR 45 SERVICE DATE
The date the indicated service was provided.

LOCATOR 46 **UNITS OF SERVICE (MANDATORY)**
Enter quantitative measure of services, as the nearest whole number, rendered by revenue category 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)**
On the first line, enter the amount to reflect the total contractual obligation for all other non-Medicaid payers according to the explanation of benefits. The total field should equal any amounts listed in locator 48.

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 corresponding plan ID number in Locator 50A, B, and C to Locator 51A, B, and C as necessary.

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 (CONDITIONALLY MANDATORY)**
Leave blank if no Medicare or primary health insurance.

If there are other payers (Medicare, other primary health insurance or cost share), enter the corresponding payment amount from the payer in Locator 54A, B, and C to Locator 51A, B, and C as necessary in 54A, B, and C.

LOCATOR 55 **ESTIMATED AMOUNT DUE (CONDITIONALLY MANDATORY)**
Leave 55A blank. Enter on 55B or 55C, which ever corresponding number from locator 50 has “999”, 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
leave blank.

LOCATOR 64 DOCUMENT CONTROL NUMBER
For adjusts and voids see "Void and Adjustment" section located below.
For all other claims 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.

LOCATOR 67 **PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)**
Enter diagnosis codes other than the principal diagnosis in form locators A-Q.

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)**
Enter the diagnosis code provided at the time of admission as stated by the physician.

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 REMARKS
Leave Blank.

LOCATOR 81 **TAXONOMY-CODE FIELD (MANDATORY)**
Required when adjudication is known to be impacted by the provider taxonomy code. 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										

Long Term Acute Care
The Prior Authorization Request Form is to be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients.

This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of

physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

QUICK ANSWERS

1. **I billed Medicare a bill type that is not a South Dakota Medicaid accepted bill type. What do I do?**

   Change the bill type to the closest South Dakota Medicaid acceptable bill type and resubmit.

2. **Can I submit a void/adjustment for a UB04 Hospice claim?**

   Yes, all claim types can be voided or adjusted. Please refer to the UB04 Void and Adjustment manual.