

SOUTH DAKOTA MEDICAID PROGRAM



Long Term Care, Assisted Living Waiver, and Community Support Provider Billing Manual

Long-Term Care, Assisted Living, & Community Support Providers Table of Contents

INTRODUCTION	1
CHAPTER I	
GENERAL INFORMATION	2
PROVIDER RESPONSIBILITY	2
<i>ENROLLMENT AGREEMENT</i>	2
<i>PROVIDER IDENTIFICATION NUMBER</i>	2
<i>TERMINATION – AGREEMENT</i>	2
<i>OWNERSHIP CHANGE</i>	3
<i>RECORDS</i>	3
THIRD PARTY LIABILITY	3
<i>SOURCES</i>	3
<i>PROVIDER PURSUIT</i>	3
<i>CLAIMS SUBMISSION</i>	3
LEAVE DAYS	3
<i>RESERVE BED DAYS</i>	4
<i>THERAPEUTIC LEAVE DAYS</i>	4
<i>PATIENT PAYMENT</i>	4
SERVICE CODING	4
PAPER CLAIMS	4
ELECTRONIC CLAIM FILING	5
<i>PAYMENTS</i>	5
RECIPIENT	5
<i>ELIGIBILITY</i>	5
<i>IDENTIFICATION NUMBER</i>	5
<i>TIME LIMITS</i>	5
<i>PROCESSING</i>	6
FRAUD AND ABUSE	6
CHAPTER II	
REMITTANCE ADVICE	7
SAMPLE REMITTANCE ADVICE	7
REMITTANCE ADVICE FORMAT	7
APPROVED ORIGINAL CLAIMS	8
DEBIT REPLACEMENT CLAIMS	8
CREDIT REPLACEMENT CLAIMS	8
VOIDED CLAIMS	8
DENIED CLAIMS	8
ADD-PAY/RECOVERY	9
REMITTANCE TOTAL	9
YTD NEGATIVE BALANCE	9
CASE MIX PENDED CLAIMS	9
SCHEDULE OF PENDED CLAIMS	11
MDS SCHEDULE	11
PAYROLL PAYMENT SCHEDULE	12

CHAPTER III

RECIPIENT ELIGIBILITY AND POLICIES 14
MEVS ELIGIBILITY INFORMATION 14
TREATMENT OF INCOME FOR LESS THAN A FULL MONTH RESIDENCE 16
ESTATE RECOVERY STATUTORY AUTHORITY 16
ORFI RECOVERY FROM PERSONAL TRUST FUNDS 16
ESTATE RECOVERY PROGRAM NOTIFICATION OF DEATH 17
AFFIDAVIT OF: ESTATE RECOVERY PROGRAM 19
NURSING HOME RELEASE OF FUNDS 20
REAL ESTATE LEIN 20
HOW TO CONTACT ORFI 20

CHAPTER IV

SWING BED AND CROSSOVER CLAIMS 21
RECIPIENTS WITH NO MEDICARE BENEFITS 21
RECIPIENTS WITH PART B MEDICARE ONLY 21
RECIPIENTS WITH PART A AND PART B MEDICARE 21

CHAPTER V

BILLING INSTRUCTIONS 23
HOW TO COMPLETE THE CMS 1450 (UB-04) CLAIM FORM 24
SPECIAL BILLING INSTRUCTIONS 30
 REPLACEMENT AND VOID CLAIMS 30
BILLING MEDICARE 31
HOW TO COMPLETE THE CMS 1450 (UB-04) CROSSOVER CLAIM 32
SPECIAL BILLING INSTRUCTIONS 39
 REPLACEMENT AND VOID CLAIMS 39

INTRODUCTION

This manual is one of a series published for the use of medical services providers enrolled in the South Dakota Medical Assistance Program. It is designed to be readily updated by replacement or addition of individual pages as necessary. **When such changes occur, providers will be notified by Remittance Advice. It is important that the provider read the Remittance Advice messages every week for updates.** It is designed to be used as a guide in preparing claims, and is not intended to address all Medical Assistance Program rules and regulations.

Problems or questions regarding Medical Assistance Program rules and policies as well as claims, covered services, and eligibility verification should be directed to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
E-Mail: Medical@dss.state.sd.us
PHONE: (605) 773-3495

PROVIDER TOLL FREE NUMBER 1-800-452-7691

***Toll free telephone number is NOT to be given to recipients. This number is only to be used by the provider.**

The telephone service unit will not give out recipient ID numbers. The Medical Assistance Program emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services (other than true emergency services). It is to the provider's advantage to see the ID card to verify that the recipient is Medical Assistance Program eligible at the time of service, as well as to identify any other program limitations and the listing of the recipient name on the Medical Assistance Program file.

Problems or questions concerning recipient eligibility requirements can be addressed by the local field Division of the Department of Social Services in your area or can be directed to:

Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, SD 57501-2291
PHONE: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by Medical Assistance Program personnel.

NOTE: If you are not currently submitting claims electronically and are interested in doing so, please contact our office for further information.

CHAPTER I

GENERAL INFORMATION

The purpose of the Medicaid Program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medicaid program was implemented in South Dakota in 1967.

Funding and control of Medicaid are shared by federal and state governments under Title XIX of the Social Security Act; regulations are written to comply with the actions of Congress and the State Legislature.

A brief description of general information about the program is provided in this manual. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing Medicaid in Article 67:16.

PROVIDER RESPONSIBILITY

ENROLLMENT AGREEMENT

Providers, who render one or more services covered under the Medicaid Program, and who wish to participate in the Medicaid Program, must become an enrolled provider. The provider must sign a Provider Agreement with the Department of Social Services. Providers must comply with the terms of participation, as identified in the agreement and requirements, stated in Administrative Rules of South Dakota (ARSD 67:16) which govern the Medicaid Program. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

Participating providers agree to accept Medicaid payment as payment in full for covered services.

An individual (i.e. consultant, staff, etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the Medicaid Program.

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a seven (7) digit identification number, assigned by the South Dakota Department of Social Services and/or a ten (10) digit National Provider Identification (N.P.I.) number.

TERMINATION AGREEMENT

When a provider agreement has been terminated, the Department of Social Services will not pay for services provided after the termination date. A provider agreement may be terminated for any of the following reasons:

- Date of the agreement has expired
- Failure to comply with conditions of participation in the agreement
- Change of ownership
- 30 days past the Department's request for a signed agreement
- Provider requests termination
- Terminated by Department for cause

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity must give the Department of Social Services written notice of the pending sale or transfer at least 30 days before the effective date. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement.

RECORDS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to Medicaid. These records must be retained for at least six (6) years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending.

Providers must grant access to these records to agencies involved in Medicaid review or investigations.

THIRD PARTY LIABILITY

SOURCES

Third-party liability is the payment source or obligation, other than Medicaid, for either partial or full payment of the medical cost of injury, disease, or disability. Payment sources include Medicare, private health insurance, worker's compensation, disability insurance, and automobile insurance.

PROVIDER PURSUIT

Because Medicaid is the last payer, **the provider must pursue the availability of third-party liability.**

CLAIMS SUBMISSION

The provider must submit the claim to a third-party liability source before submitting it to Medicaid except for the following:

- Prenatal care for a pregnant woman;
- HCBS waiver services;
- Services for early and periodic screening, diagnosis, and treatment provided under chapter 67:16:11, except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements;
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department;
- The probable existence of third-party liability cannot be established at the time the claim is filed; or
- The claim is for services provided by a school district under the provisions of chapter 67:16:37.

A claim submitted to Medicaid must have the third-party explanation of benefits (EOB) attached, when applicable.

LEAVE DAYS

RESERVE BED DAYS

Reserve bed days are days that the recipient is absent from the nursing facility due to an inpatient hospital stay. Reserve bed days must be ordered by a physician.

The recipient may be absent from the long term care facility for a maximum of five days. Before additional reserve bed days may be taken, the recipient must return to the facility for 24 hours.

THERAPEUTIC LEAVE DAYS

Non-medical leave days are leave days from the long term care facility for non-medical reasons (e.g., visits to the homes of family or friends). The attending physician must approve the leave and certify that the leave is not contrary to the patient's plan of care.

Therapeutic leave days are leave days from the long term care facility prescribed by the physician for therapeutic and/or rehabilitative reasons (e.g., participation in summer camps, or special therapeutic or rehabilitative programs). Therapeutic leave days must be approved by the recipient's physician.

The recipient may be absent from the long term care facility for a maximum of fifteen consecutive days. Before any more therapeutic leave days may be taken, the recipient must return to the facility for 24 hours.

Recipients in assisted living waiver facilities are allowed a total of five (5) hospital reserve bed days and/or therapeutic leave days per month.

Adjustment training centers should contact the Department of Human Services (DHS) for information regarding leave days for their Medicaid recipients.

PATIENT PAYMENT

Patient payment is payment made by the recipient for nursing facility care after the personal needs allowance is deducted. This income must be applied to the patient's care.

When reporting patient payment for the entire month, regardless of the number of days in that month, apply the total patient obligation.

SERVICE CODING

The following tables identify the only valid revenue codes that should be used to bill nursing facility services to the Medicaid program. Valid revenue codes are not always a Medicaid benefit. Claims submitted with revenue codes that are not listed below are non-covered. Revenue code 001 is valid and is required to total the detail line charges on each Medicaid UB-04 claim.

Valid nursing facility and assisted living facility waiver revenue codes

Revenue Code	Description
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 Vacuum
291	Specialty Bed/Mattress Service
412	Ventilator
919	Extreme Behavior
001	Grand total on last line

ADD-ON REVENUE CODES

Add-on revenue codes are to be billed on the claim form in addition to the standard daily service revenue codes. To be reimbursed for add-on revenue codes a provider must have a contract with the Department of Social Services and received written authorization to provide these additional services.

PAPER CLAIMS

Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper. Paper nursing facility and assisted living facility claims must be submitted on the UB-04 (HCFA-1450) claim form.

ELECTRONIC CLAIM FILING

If you do not currently file claims electronically, please consider doing so in the near future. Electronic filing offers you several advantages, including:

- Claims are entered into the system directly, with less human intervention
- Claims may be entered any time of day, any day
- Claim filing deadlines are more generous
- Claims are paid faster and more accurately
- Electronic filing costs are offset by the efficiency

Electronic claims must be submitted using the 837I, HIPAA-compliant X12 format

PAYMENTS

When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

When third-party liability source(s) and Medicaid have paid for the same service the provider must reimburse Medicaid. Reimbursement must be either the amount paid by the third party source(s) or the amount paid by Medicaid, whichever is less.

RECIPIENT

ELIGIBILITY

Eligibility for Medicaid benefits is strictly limited. Eligibility is renewed on a monthly basis. Providers should ask for the recipient ID card with each visit, and check eligibility using the options available through WebMD or the South Dakota Medicaid Voice Response 1-800 number.

IDENTIFICATION NUMBER

An eligible South Dakota Medicaid recipient is assigned a fourteen (14) digit Medicaid identification number. Only the last nine (9) digits of the Medicaid ID number are shown on the South Dakota Medicaid Identification Card.

TIME LIMITS

The department must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in ARSD § 67:16:35:04. This time limit may be waived or extended only when one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;

- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
- The claim is received within 3 months after a previously denied claim;
- The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance;
- To correct an error made by the department

PROCESSING

The Division of Medical Assistance processes claims submitted by providers for their services as follows:

- Claims and attachments are received by the Division of Medical Assistance and sorted by claim type and microfilmed.
- Each claim is assigned a unique fourteen- (14) digit **Reference Number**. This number is used to enter, control and process the claim. An example of a reference number is 2003002-000015-0.
- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice. To determine the status of a claim, **providers must reconcile the information on the Remittance Advice with their files.** (See Chapter II)

FRAUD AND ABUSE

The South Dakota Medicaid Fraud Control Unit (MFCU), under the Office of Attorney General, is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program. Civil or criminal action or suspension from participation in the Medicaid program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits or Payments from the Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and ARSD Article 67:16.

CHAPTER II

REMITTANCE ADVICE

A Remittance Advice serves as the Explanation of Benefits (EOB) from the Medical Assistance Program. The purpose of this chapter is to familiarize the provider with the design and content of the Remittance Advice. The importance of understanding and using this document cannot be stressed enough. The current status of all claims, (including replacements and voids) that have been processed during the past week are shown on the Remittance Advice. It is the provider's responsibility to reconcile this document with patient records. The Remittance Advice documents all payments and denials of claims and should be kept for six years, pursuant to SDCL 22-45-6.

SAMPLE REMITTANCE ADVICE

CANTON GOOD SAMARITAN CNTR 1022 N DAKOTA ST. CANTON, SD 57013-1004	NURSING HOME REMITTANCE ADVICE 04/18/2007	DEPT. OF SOCIAL SERVICES MEDICAL SERVICES 700 GOVERNORS DRIVE PIERRE., SOUTH DAKOTA 57501-2291														
PROVIDER NO: 0150000 FED TAX ID NO.: 123456789 NPI: 9876543210		PAGE NO. 1														
THE FOLLOWING CLAIMS ARE APPROVED ORIGINALS:																
REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	DIR RATE	NDIR RATE	LOC	F R	THRU DATE	DAYS	CM CLASS	CM WEIGHT	CHARGES BY CLASS	CHARGE	CREDITS	PAID BY PROG	PAT STA	
2006303-722200-0	000111222	DOE, JOHN M	52.22	62.66	6		03-01-07	03-10-07	10	PE1B	1.1000	1,201.00				
PAT ACCT NO. 02211111							03-11-07	03-31-07	21	PE1B	1.1000	2,522.10	4,104.40	.00	3,723.10	30
2006300-711100-0	000222111	DOE, JANE A	50.62	55.75	6		03-03-07	03-31-07	29	SE2B	2.1900	4,831.40	4,831.40	641.72	191.33	30
PAT ACCT NO. 01122222																
TOTAL APPROVED ORIGINALS: 2												8,935.80	641.72			
THE FOLLOWING CLAIMS ARE DENIED:																
REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	FROM DATE	THRU DATE	BILLED CHARGE	DENY REASON										
2006302-322211-0	000333444	Smith, Alfred B.	03-01-07	03-31-07	2,653.91	RECIPIENT INDIVIDUAL RECORD NOT ON FILE (ORIG)										
PAT ACCT NO. 03344444																
TOTAL DENIED CLAIMS: 1																
												REMITTANCE TOTAL	3,914.43			
												YTD NEGATIVE BALANCE	.00			
												AMOUNT OF ACH CREDIT	3,914.43			
												ACH CREDIT DATE	04/30/2007			
MMIS REMIT NO: 71122334																
IF ERRORS ARE FOUND ON THE ABOVE REMITTANCE ADVICE, PLEASE NOTIFY THE DEPARTMENT OF SOCIAL SERVICES																

REMITTANCE ADVICE FORMAT

Each claim line is processed separately.

Use the correct reference number (see chapter 1) to ensure that you correctly follow each line of a claim.

The following information explains the Remittance Advice format:

HEADER INFORMATION:

- Provider name and address;
 - Type of Remittance Advice (e.g. nursing home, physician, pharmacy, crossover, etc.) and date;
 - Medical Assistance Program address and page number;
- and
- Medical Assistance Program provider ID number, federal tax I.D. number, and National Provider Identification number.

Only the last nine (9) digits of the recipient's 14 digit identification number are displayed.

MESSAGES:

The Remittance Advice is used to communicate special information to providers. Policy changes, service limitations, and billing problems are examples of messages that may be published in this section. **READ CAREFULLY ALL MATERIAL PRINTED IN THESE MESSAGES AND ENSURE THAT THE APPROPRIATE STAFF RECEIVES A COPY OF THE MESSAGE.**

APPROVED ORIGINAL CLAIMS

A claim is approved and then paid if it is completed and correctly prepared for a Medical Assistance Program covered service(s) provided to an eligible recipient by a Medical Assistance Program enrolled provider. Claims that have been determined payable are listed in this section with the amount paid by Medical Assistance Program.

DEBIT REPLACEMENT CLAIMS

A replacement can be processed only for a claim that has previously been paid. When replacing a claim, resubmit the complete original claim with the corrections included or deleted as appropriate.

NOTE: Once you have replaced a claim you cannot replace or void the original claim again.

CREDIT REPLACEMENT CLAIMS

This is the other half of the replacement process. The reference number represents the original paid claim. Information in this section reflects the Medical Assistance Program processing of the original paid claim. This information is being replaced by the correct information, listed in the section above (THE FOLLOWING CLAIMS ARE DEBIT REPLACEMENTS).

VOIDED CLAIMS

This section subtracts claims that should not have been paid. The first reference number represents the voided claim. The second reference number represents the original paid claim (the claim that is being voided). Transactions on this line show a negative amount for the provider.

NOTE: Once you have voided a claim, you cannot void or adjust the same claim again.

DENIED CLAIMS

A claim is denied if one or more of the following conditions exist:

1. The service is not covered by the Medical Assistance Program;
2. The claim is not completed properly;
3. The claim is a duplicate of a prior claim;
4. The data is invalid or logically inconsistent;
5. Program limitations or restrictions are exceeded;
6. The service is not medically necessary or reasonable; and
7. The patient and/or provider is not eligible during the service period.

Providers should review denied claims and, when appropriate, completely resubmit the claim with corrections. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or the Medical Assistance Program policy.

Claims that cannot be paid by Medical Assistance Program are listed in this section. Even though there may be several reasons why a claim cannot be paid, only one denial reason will be listed.

ADD-PAY/RECOVERY

When an adjustment or void has not produced a correct payment, a lump sum payment or deduction is processed. There is no identifying information on the Remittance Advice explaining for which recipient or services this payment is made for, but a letter is sent to the provider explaining the add-pay/recovery information. If the amount is to be recovered from the provider there will be a minus sign behind the amount; otherwise the amount is a payment to the provider.

REMITTANCE TOTAL

The total amount is determined by adding and subtracting all of the amounts listed under the column **PAID BY PROGRAM**.

YTD NEGATIVE BALANCE

A Year-to Date (YTD) negative balance is posted in one of two situations. When ONLY void claims are processed in a payment cycle for the provider and no original paid claims are included on the Remittance Advice, a negative balance is displayed. When the total amount of the negative transactions, such as credit replacement and void claims, is larger than the total amount of positive transactions (original paid and debit replacements), a negative balance will be shown.

MMIS REMIT NO ACH AMOUNT OF CHECK

The system produces a sequential Remittance Advice number that is used internally for finance purposes and relates to the check/ACH issue to the provider. The net check amount is the Remittance Total minus the YTD Negative Balance.

PENDED CLAIMS – THE FOLLOWING CLAIMS ARE PENDED FOR REVIEW – PROVIDER DOES NOT NEED TO TAKE ACTION UNLESS FURTHER CONTACT IS MADE:

A claim that cannot be automatically paid or denied through the normal processing system is pended until the necessary corrective action has been taken. Claims may be pended because of erroneous information, incomplete information, information mismatch between the claim and the state master file, or a policy requirement for special review of the claim. The reason for pending the claim is printed on the Remittance Advice. The provider should wait for claim payment or denial before resubmitting the claim. After a pended claim has been approved for further processing, it is reprocessed and appears on the subsequent Remittance Advice as an approved original either as a paid or a denied claim.

DO NOT SUBMIT A NEW CLAIM FOR A CLAIM IN PENDED STATUS, UNLESS YOU ARE ADVISED BY THE DEPARTMENT TO DO SO.

IF ERRORS ARE IDENTIFIED ON THE REMITTANCE ADVICE, PLEASE NOTIFY THE MEDICAL ASSISTANCE PROGRAM AT 1-800-452-7691 AS SOON AS POSSIBLE.

CASE MIX PENDED CLAIMS

As of July 1, 1992, the Department implemented the Case Mix Reimbursement System for Nursing Facilities. This system has created unique reasons for pending a claim, and each provider **must pay close attention to the case mix pended messages** to determine the necessary corrective action needed to receive payment. The case mix pended reasons corrective actions are listed as follows:

The following corrective actions are based on the most common Case Mix pended reasons and are not intended to cover all possible Case Mix pended claims scenarios. Additional corrective action may be necessary depending on the situation. Additional corrective actions are addressed on a case by case basis.

A claim may pend, or deny for other reasons, such as duplication of a claim, incorrect credit amount, or recipient not a valid long term care recipient. For all pended reasons, other than the new case mix error reasons continue current practices. If you require assistance you should contact the Medical Assistance Department.

CLASSIFICATION EFF DATES ARE NOT COVERING CLAIM

This error is noted on the Remittance Advice with a warning (*) by the resident classification. This error occurs when the resident classification dates are not covering the claim period or a record was found on the state's case mix database but the classification dates didn't cover the entire claim, or the classification dates may not have covered any of the claim. The claim will pay, and payment will be based on the MDS in the system (previous MDS). **The most common reason for this error, to date, is due to either early or late completion of the MDS.**

Corrective action:

To correct this error, the nursing facility must submit the current, scheduled MDS. If payment is not acceptable, the facility must adjust the claim to the correct payment amount.

M3PI – BC1B CLASSIFICATION ERROR

This error occurs because the resident assessment (MDS) cannot be classified. Some possible reasons for this error could pertain to an incomplete assessment or data encoding error(s) etc.

Corrective Action:

The facility needs to submit a Corrective Inactivation to void the **Invalid Assessment** and then proceed with procedures to submit the accurate MDS assessment

NO TITLE-XIX NUMBER ON CASE MIX DATA FILE

This occurs because the Title XIX number is missing or incorrectly encoded and/or the medical record number is incorrect or missing on the State's Case Mix data base for the resident. The Case Mix data system is updated with this number by the MDS process, and when this error occurs, for whatever reason, the computer payment system cannot process the claim as it considers the resident ineligible for payment.

Corrective Action:

When this error occurs, the facility needs to complete and electronically submit a Correction Modification request to the MDS database. The facility should then follow the appropriate procedure to include the T-XIX number on the OBRA (clinical) assessment that establishes the classification for the billing period. This is probably going to be the OBRA assessment prior to the month of eligibility.

RESERVE BED DAYS EXCEED 72 HOURS W/O ASSESSMENT TERMINATION

This error is in reference to the state's reserve bed day policy and it occurs because the resident was admitted to a hospital for a period of time in excess of 72 hours but no Discharge Tracking form was submitted to the MDS database.

Please be advised that the state will still pay for 5 reserve bed days, as this policy has not changed. However, the case mix payroll system has been programmed to protect the integrity of the system, and as such will pend any claim that is not in compliance with the MDS completion policy.

Corrective Action:

The facility must submit a Discharge Tracking form coded *Discharge Return Anticipated (07)*.

SCHEDULE OF PENDED CLAIMS

Case Mix pended claims remain in the system for the first (original pend) payroll only. If the pended claims have not been corrected before the supplemental run, the **claim is denied**. If a claim is denied, the facility must resubmit the claim on the UB-04 claim form to repeat the process.

Considering the information that is supplied to the facilities via the Census Report and Error Reports, adequate time is allowed for the facility to submit the necessary corrective action to process payment and avoid unnecessary payment delays. This process also reduces the number of retroactive claim payments and reduces the burden on facility payroll personnel in tracking resident payment.

Case Mix errors are generally due to inadequate completion or submission of required forms. Therefore, as a preventive measure, we would like to review the MDS schedule, and remind everyone of the importance of the information on the Facility Census and Error Reports. Please adhere to these reports when received.

MDS SCHEDULE

MDS DUE DATES	COMPLETION TIMEFRAME	EFFECTIVE PAYMENT DATES
Day 14	Day 1 – 14	Admission Date – 90 days
Day 90	Day 76 – 90	Day 91 – Day 180
Day 180	Day 166 – 180	Day 181 – Day 270
Day 270	Day 256 – 270	Day 271 – Day 360
Day 360	Day 346 – 360	Day 361 – Day 90
Process starts over		
Day 90		Day 91 – Day 180

WEEKLY SUBMISSION OF COMPLETED ASSESSMENTS IS ADVISED

If the above completion time frames are followed and the MDS files are submitted weekly, the number of pended claims should be significantly reduced.

MDS DUE DATE – The day the MDS is due. The last day of the time period in which to complete the assessment.

COMPLETION TIME FRAME – The window of time in which the MDS can be completed.

EFFECTIVE PAYMENT DATE – The payment period per MDS classification. Using the 90 day assessment, the payment changes on day 91 if the MDS classification warrants the change. The new payment is effective through day 180, unless a significant change occurs.

The payment change date can also be determined from the “Facility Resident Census/Status Report” by using the column “Assessment Schedule Is Due By.” The payment change effective date is the day after the day reported in this column.

EXAMPLE:	Assessment may begin	Schedule due:
	09/30/2006	10/13/2006

These two columns represent the completion time frame for the required MDS. In this example, the effective day of a payment change, if warranted by the MDS classification, would be 10/13/06.

PAYROLL PAYMENT SCHEDULE

The Medicaid reimbursement system *regular payroll* runs on the first Wednesday on or after the 10th of each month. The following day, the nursing home, assisted living waiver, and adjustment training center reimbursement remittance advice and the check, (if the facility is not receiving an ACH deposit), are mailed to the facility. This payment to the facility is for the preceding month of care. A second (*supplemental*) payroll runs two weeks after the regular payroll and is used to process and reimburse pending claims that have been reviewed.

REGULAR MONTHLY PAPER CLAIMS MUST BE RECEIVED BY THE 5TH OF EACH MONTH TO ENSURE PROPER PAYMENT.

ELECTRONIC CLAIMS MAY BE HELD AND SUBMITTED UP TO THE TUESDAY BEFORE THE PAYROLL RUNS.

Please remember the following pointers to assist you in having your claims paid promptly and accurately:

- Always return your claims by the 5th of the month.
- Don't combine months on the UB-04 claim form. Enter each month on a separate claim.
- Submit your UB-04 claim request for payment only once a month.
- The Medical Assistance Office is only the payment agent. We can not update a person's eligibility file, MDS, credit amount, or discharge dates.
- When submitting UB-04 claims, bill for months of services prior to the month you submit the claim. EXAMPLE: Claims submitted in August must have dates of service in July or earlier.
- Never submit a claim for a pending request. Pending claims will be reviewed by the medical services office.
- When calling the State Office (1-800-452-7691 or 605-773-3495) regarding remittance advice errors, please have the following information on hand:
 - Provider Number
 - Recipient Number
 - Reference Number of claim
- The only way for a caseworker to keep informed of a client's status is through you. When a patient is deceased or is discharged you MUST notify the caseworker of the patient's status, and report it on your claim.
- Please review your remittance advice prior to submitting the next month's claims, so errors can be corrected as soon as possible.
- DO NOT submit claims for a new patient until you have received authorization for the recipient from the caseworker.
- Each claim must be for 31 days or less.
- When a patient is discharged to home, the credit amount for that month is returned to the patient.

The remittance advice is the provider's record of claims processed by Medicaid. Questions or the correction of errors can be addressed more effectively if Medical Services is notified immediately of the problem.

UB-04 (HCFA 1450) CLAIM FORM

Nursing Home, Assisted Living Waiver providers and Adjustment Training Centers are required to submit claims for their residents on the UB-04 claim form. The UB-04 (HCFA 1450) is a standard form that is mandated for use by all nursing homes and hospitals to bill patient services. The UB-04 is a multi-part form. It is designed to be typed or computer printed (all typing must be done in upper-case letters).

Claim forms are not supplied by Medicaid but must meet the requirements of the South Dakota UB-04 committee. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for affixing proper postage.

CHAPTER III

RECIPIENT ELIGIBILITY AND POLICIES

The South Dakota Medical Assistance Identification Card is issued by the Department of Social Services on behalf of eligible Medical Assistance Program recipients. The magnetic strip card has the same background as the Food Stamp EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial and last), the nine digit recipient ID (RID#) plus a three digit generation number, and the recipient's date of birth and sex.

NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on the claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present their Medical Assistance Program identification card to a Medical Assistance Program provider each time, before obtaining a Medical Assistance Program covered service. Failure to present their Medical Assistance Program identification card is cause for payment denial. Payment for denied services becomes the responsibility of the recipient.



The Medicaid Eligibility Verification System (MEVS) offers three ways for a provider to access the state's recipient eligibility file:

- Point of Service terminal: (swipe device similar to credit care verification) which may be purchased or leased.
- PC Software: The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- Secure Web based site.

All three options provide prompt response times and printable receipts, and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through WebMD Envoy.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket" sent to the provider.

Please note that certain Medical Assistance Program recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

*****SD MEDICAID*****

Eligibility
10/19/2004 08:47:25

*****PAYER INFORMATION*****

Payer: SOUTH DAKOTA MEDICAL SERVICES
Payer ID: SD48MED

*****PROVIDER INFORMATION*****

Provider: MID-DAKOTA HOSP
Service Provider#: 9999999

*****SUBSCRIBER INFORMATION*****

Current Trace Number: 200406219999999
Assigning Entity: 9000000000
Insured or subscriber: Mertz, Ethel R.
Member ID: 999999999
Address: Pierre Living Center
2900 N HWY 290
PIERRE, SD 57501-1019

Date of Birth: 06/21/1908
Gender: Female

*****ELIGIBILITY AND BENEFIT INFORMATION*****

*****HEALTH BENEFIT PLAN COVERAGE*****

ACTIVE COVERAGE

Insurance Type: Medicaid
13
Eligibility Begin Date: 10/19/2004

ACTIVE COVERAGE

Insurance Type: Medicare Primary
13
Eligibility Date Range: 10/19/2004 –
10/19/2004

*****HEALTH BENEFIT PLAN COVERAGE*****

*****OTHER OR ADDITIONAL PAYER*****

Insurance Type: Other
Benefit Coord. Date Range: 10/19/2004-
10/19/2004
Payer: BLUE CROSS/BLUE SHIELD
Address: 1601 MADISON
PO BOX 5023
SIOUX FALLS, SD 57111-5023

Information Contact:
Telephone: (800)774-1255

TRANS REF #: 999999999

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-760-2804, #536. To add new payers, call 800-215-4730.

**TREATMENT OF INCOME FOR LESS THAN A FULL MONTH RESIDENCE ARSD
§ 67:46:06:09**

Whenever the residence period in a long term care facility is less than a full month, the recipient's income shall not be applied toward the cost of care unless the recipient dies or is transferred to another long term care facility. In the event of death or transfer, the income shall be used as a credit toward the cost of care.

General Authority: **SDCL 28 – 6 – 1**

Law Implemented: **SDCL 28 – 6 – 1**

ESTATE RECOVERY STATUTORY AUTHORITY: SDCL 34-12-38 and SDCL 28-6-23

“Upon the death of a resident, the Department of Social Services is entitled to recover any funds of the resident kept or maintained by the home or other facility if the resident was receiving medical assistance from the department at the time of death. The home or other facility may not release or transfer any property under Section 34-12-15.10 until it has determined that the Department of Social Services has no interest in or right to the property. The department shall file an affidavit pursuant to SDCL 29-A-12,01 to establish its right to recover such funds.”

ORFI RECOVERY FROM PERSONAL TRUST FUNDS

How Office of Recoveries and Fraud Investigation Will Recover

- Notification of Death to be completed by Nursing Home
- If funds exist, ORFI will file a request for release of funds - Affidavit
- ORFI will work with Nursing Home to secure recovery



FINAL TRUST FUND RECONCILIATION

AMOUNT IN PERSONAL TRUST ACCOUNT ON DATE OF DEATH \$ _____
ADD DEPOSITS AND/OR CREDIT BALANCES \$ _____

SUB TOTAL OF TRUST FUND \$ _____

LESS FINAL EXPENSES PAID FROM PERSONAL TRUST FUND
(ATTACH COPY OF CHARGES AND PROOF OF PAYMENT)

FUNERAL COSTS \$ _____
HEADSTONE COST \$ _____
CREMATORIUM COST \$ _____
OTHER - PLEASE LIST:
_____ \$ _____
_____ \$ _____
_____ \$ _____

TOTAL FINAL EXPENSES PAID \$ _____
BALANCE FOR DSS \$ _____

(IN ACCORDANCE WITH SDCL 29A-3-817 AND SDCL34-12-38)

**IF THERE IS A SURVIVING SPOUSE THERE IS NO RECOVERY BY DSS.
IF FUNERAL EXPENSES HAVE BEEN PAID THE BALANCE MAY BE SENT IN.**

COMPLETED BY: _____

SIGNATURE

NAME (PRINT)/TITLE/POSITION

NURSING FACILITY NAME

NURSING FACILITY MAILING ADDRESS

NURSING FACILITY PHONE NUMBER

DATE COMPLETED: _____

RETURN THIS FORM TO: DEPARTMENT OF SOCIAL SERVICES
OFFICE OF RECOVERIES AND FRAUD INVESTIGATIONS
ESTATE RECOVERY PROGRAM
700 GOVERNORS DRIVE
PIERRE SOUTH DAKOTA 57501-2291

FOR INFORMATION CONTACT: ESTATE RECOVERY PROGRAM AT 605-773-3653
The Facility must also notify the local eligibility caseworker of the death of a Medicaid recipient.

DSS-RE-831-01/2002

STATE OF SOUTH DAKOTA)
 :SS
COUNTY OF HUGHES)

IN THE MATTER OF

(DECEASED)

AFFIDAVIT OF: ESTATE RECOVERY PROGRAM

Comes now ESTATE RECOVERY PROGRAM of the Department of Social Services, Office of Recoveries and Investigations, after being duly sworn, deposes and says:

1. I have been designated by the secretary of the Department of Social Services of the State of South Dakota to be the administrator of SDCL 28-6-23, SDCL 34-12-38 and SDCL 29A-3-817.
2. This affidavit is being made in accordance with SDCL 28-6-23, SDCL 34-12-38, SDCL 29A-3-817, and 29A-3-1201, to collect funds of a deceased nursing home resident in the amount equal to the medical assistance benefits paid by the South Dakota Department of Social Services on behalf of the decedent while the decedent resided in a nursing home.
3. _____ who died on _____, received medical assistance

 NAME DATE

benefits from the South Dakota Department of Social Services' Medical Assistance program while residing in a nursing home. The amount of medical assistance benefits the decedent received is \$_____.

4. No application or petition for appointment of a personal representative is pending or has been granted in any jurisdiction.
5. That the funeral expenses of the decedent have been paid. OR that the funeral expenses of the decedent have not been paid, but unpaid funeral expenses will be paid first from the personal funds of _____ by the South Dakota Department of Social Services and the name and address of the person entitled to the reimbursement for such funeral expense is _____.

6. That 30 days have elapsed since the death of the decedent.
7. That the gross value of the personal estate of _____, decedent, does not exceed the sum of fifty thousand dollars in value(\$50,000.00); That the purpose of this affidavit is to secure the release of the lesser of \$_____ or the remaining balance held in _____ resident account, at the _____.

8. Pursuant to the provisions of SDCL 28-6-23, SDCL 34-12-38, SDCL 29A-3-817, and SDCL 29A-3-1201, the undersigned hereby requests that the Administrator of _____ release the lesser of \$_____ or the remaining balance payable to the South Dakota Department of Social Services and mailed to South Dakota Department of Social Services, Recoveries & Investigations, 700 Governors Drive, Pierre, SD 57501-2291.

Dated at Pierre, County of Hughes, State of South Dakota this _____ day of _____, 200_____.

Signature
Estate Recovery Program

Subscribed and Sworn to before me this _____ day of _____, 200_____.

Notary Public-South Dakota
My commission expires: _____

(SEAL)

NOTICE

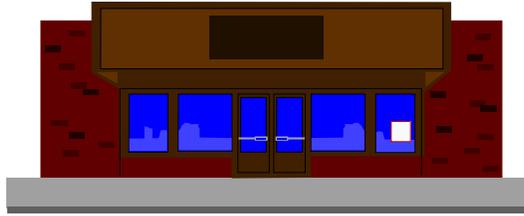
If you feel this affidavit was submitted in error you may contact the Department of Social Services, Office of Recoveries and Investigations, 700 Governor's Drive, Pierre SD 57501-2291 or Phone (605) 773-3653.

NURSING HOME RELEASE OF FUNDS

Do and Don't

- DO
 - Notify DSS upon death of resident
 - Release funds for burial costs only if there is no prepaid burial trust or burial fund
 - payment to be made directly to cemetery or mortuary
 - documentation is required
 - Release funds upon receipt of affidavit

- DON'T
 - Release funds to entities other than DSS, without a release from the Department



Statutory Authority:

SDCL 28-6-23 and 28-6-24

“Any payment of medical assistance by or through the Department of Social Services to an individual who is an inpatient in a nursing home, and intermediate care facility for the mentally retarded, or other medical institution is a debt and creates a medical assistance lien against any real property in which the individual has any ownership interest.”

REAL ESTATE LIEN

- Medical Assistance Lien Criteria
 - Intent to return home at time of application
 - Response to Line Q1C of MDS form
 - Answer – **NO**
 - Notice of intent to place lien
 - Notice sent by certified mail
 - Prepare lien for filing

 - Answer - **YES** or **UNKNOWN**
 - Review MDS 3 months later
 - **YES** still marked after 13 months
 - Obtain assessment from medical review team



HOW TO CONTACT ORFI



Department of Social Services
Office of Recoveries and Fraud Investigations
700 Governors Drive
Pierre, SD 57501-2291
Tel. (605) 773-3653
Fax (605) 773-3359

CHAPTER IV

SWING BED AND CROSSOVER CLAIMS

Purpose

On occasion, a recipient is ready to be discharged from the hospital, but is unable to go home and no nursing facility bed is available. In this case, the recipient is kept in the hospital, in Outpatient status, in a Swing Bed. Claims for a Swing Bed patient is submitted the same as claims for a nursing facility recipient, unless the recipient is Medicare eligible. Claims for a recipient who is Part A Medicare (Skilled Care) eligible must first be submitted to Medicare. All outpatient services for a Part B Medicare eligible recipient must also be first submitted to Medicare.

RECIPIENTS WITH NO MEDICARE BENEFITS

- Room and Board is billed on the UB-04, similar to Nursing Home claims. Medical surgery supplies are included in the Room and Board rate.
- Pharmacy is billed on the pharmacy claim form.
- Ancillary charges should be billed on the UB-04 claim form, as outpatient hospital services for laboratory services, radiology, and therapy.



RECIPIENTS WITH PART B MEDICARE ONLY

- Room and Board is billed on the UB-04.
- Pharmacy is billed on the pharmacy claim form.
- Ancillary Charges should be submitted to Medicare first.

When Medicare approves the claim, submit it as a UB-04 crossover claim, if it does not automatically cross over from Medicare, for the remaining co-insurance and/or deductible. Claims that cross over automatically can be identified by the reference number. The 8th digit is **7, 8, or 9** e.g. 2003023-800012-0. Ensure that the Medicare EOMB is attached to the claim.

When Medicare denies the claim, it should be submitted as a UB-04 outpatient claim. Charges should only include laboratory services, radiology, and therapy. Medical and surgical supplies and oxygen should not be included with ancillary charges, as they are part of the room rate.

RECIPIENTS WITH PART A AND PART B MEDICARE

- Room and Board:
 - Skilled Care should be billed to Medicare first
 - Days 1 – 20 are paid in full by Medicare. Medicaid should not be billed for these days.
 - Days 21 to 100 may not be paid in full by Medicare and are subject to the Medicare co-payment requirements. The room rate will appear on the EOMB. This amount should be billed to Medicaid as a crossover claim.
 - Over 100 days are Life-time Reserve days, (LTR). These should be billed the same as 21 to 100 day claims.
- Ancillary Charges – Same as Part B.

Please note the following fields when completing a Medicare Part A crossover claim:

- 24 – 30 Condition Codes - Enter code X0.
- 32 – 35 Occurrence Codes - Enter code 50 (Medicare paid) or code 51 (Medicare denied) and the Medicare RA date.
- 39 - 41 Value Codes - Enter the appropriate value code and related dollar amount that identifies Medicare Coinsurance and Medicare payment amount.
- Rates - Enter Nursing Facility's Medicaid rate.
- Payer - Enter Medicaid on the appropriate payer line.
- Provider Number - Enter the Nursing Facility's seven digit Medicaid provider number on the line selected for Medicaid.
- Cert. SSN. HIC Number - Enter the recipient's Medicaid State ID number on the line selected for Medicaid.

CHAPTER V

BILLING INSTRUCTIONS

LONG-TERM CARE, ASSISTED LIVING, COMMUNITY SUPPORT PROVIDER (CSP), OR INTERMEDIATE CARE FACILITY (ICF-MR) USING THE UNIFORM BILLING CLAIM FORM CMS 1450 (UB-04).

Claim forms are not supplied by The South Dakota Medical Assistance Program but must meet the requirements of the South Dakota UB-04 committee.

The claim is a multiple-part form. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for the proper postage.

CODES

The codes specified for use in a Medicaid Management Information System (MMIS) by the Department of Health and Human Services (HHS), CMS are:

For Diagnosis	ICD-9-CM, Internal Classifications of Diseases 9th Edition, Clinical Medicine
For Procedures	Same as diagnosis
Outpatient Laboratory	HCPCS or CPT/4
Outpatient Surgical Procedures	HCPCS or CPT/4

ICD-9-CM code books may be purchased from:

Medicode
5225 Weyley Post Way, Ste 500
Salt Lake City, UT 84116-2889

SUBMISSION

The Medical Assistance program must receive a provider's completed claim form within 6 months following the month the services were provided, unless third party liability insurance is involved or initial retroactive eligibility is determined.

A provider may only submit a claim for services he knows or should have known are covered by the Medical Assistance program.

A claim must be submitted at the provider's usual and customary charge for this service on the date the service was provided.

The name which appears on the remittance advice indicates the provider name which the Medical Assistance program associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

HOW TO COMPLETE THE CMS 1450 (UB-04) CLAIM FORM

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by the Medical Assistance program.

The following information is a locator by locator explanation of how to prepare the CMS 1450 (UB-04) claim form.

- LOCATOR 1** PROVIDER NAME, ADDRESS & TELEPHONE NUMBER
Enter the name of the provider submitting the bill, address, city, state, zip code, and telephone (**MANDATORY**) Fax and Country (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. (See below the only acceptable codes under the South Dakota Medical Assistance Program.)
- Long Term Care
211 Admission through Discharge
212 Interim First Claim
213 Interim Continuing Claim
217 Replacement
218 Void
- LOCATOR 5** FEDERAL TAX NUMBER
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)
Enter in 8a the patient's Medicaid I.D. number from the patient's South Dakota Medical Assistance card. Enter in 8b the patient's full name.
- LOCATOR 9** PATIENT ADDRESS
Enter in 9a the patient's address, 9b city, 9c state, 9d zip code, and 9e country.
- LOCATOR 10** PATIENT BIRTHDATE
Enter patient's birthdate.

- LOCATOR 11** PATIENT SEX
Enter patient's sex.
- LOCATOR 12** ADMISSION/START OF CARE DATE
Enter the date the patient was admitted.
- LOCATOR 13** ADMISSION HOUR
Leave Blank not Required for Long-Term Care Claims
- LOCATOR 14** TYPE OF ADMISSION
Leave Blank not Required for Long-Term Care Claims.
- LOCATOR 15** SOURCE OF ADMISSION
Leave Blank not Required for Long-Term Care Claims.
- LOCATOR 16** DISCHARGE HOUR
Leave Blank not Required for Long-Term Care Claims.
- LOCATOR 17** PATIENT STATUS (MANDATORY)
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 the South Dakota Medical Assistance Program.)
- 01 Discharges home or self-care (routine discharge) including discharges to foster homes, group homes, halfway houses, and supervised personal care facilities as well as private residences.
 - 02 Discharges/transfers/referrals to another short term general hospital such as acute care hospitals, public health service hospitals, neonatal units, etc.
 - 03 Discharges/transfers to skilled nursing facilities (SNF) including swing beds, sub acute care centers and Medicare nursing facilities as well as skilled nursing homes.
 - 04 Discharges/transfers to intermediate care facilities (ICF) including community support providers, South Dakota Development Center, as well as regular nursing homes.
 - 05 Discharges/transfers/referrals to another type of institution such as rehabilitation hospitals or units, military or VA hospitals, Assisted Living Centers, etc.
 - 06 Discharges/transfers to home under the care of an organized home health service organization.
 - 07 Left against medical advice.
 - 20 Expired
 - 30 Still an inpatient. This is an invalid code except for DRG-exempt Hospital/Unit claims and Nursing Home.
 - 40 Expired in a medical facility
- INVALID CODES:**
09, 11-19, 21-29, 31-39, 41-99 these are all invalid codes which should not be used for Long-term care claims.

<i>LOCATOR 18-28</i>	<u>CONDITION CODES</u> A code(s) used to identify conditions relating to this bill that may affect payer processing.
<i>LOCATOR 29</i>	<u>ACCIDENT STATE</u> The two letter state abbreviation the accident occurred in. (if applicable)
<i>LOCATOR 30</i>	<u>UNLABELED FIELD</u> Leave Blank
<i>LOCATOR 31-34</i>	<u>OCCURRENCE CODES AND DATES</u> The code and associated date defining a significant event relating to this bill that may affect payer processing. Occurrence code: 50 – Medicare Pay Date 51 – Medicare Denial Date 53 – Late Bill Override Date
<i>LOCATOR 35-36</i>	<u>OCCURRENCE SPAN CODE AND DATES</u> 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
<i>LOCATOR 37</i>	<u>UNLABELED FIELD</u> Leave Blank
<i>LOCATOR 38</i>	<u>RESPONSIBLE PARTY NAME AND ADDRESS</u> The name and address of the party responsible for the bill.
<i>LOCATOR 39-41</i>	<u>VALUE CODES AND AMOUNTS</u> A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payer organization.
<i>LOCATOR 42</i>	<u>REVENUE CODE (MANDATORY)</u> Enter the code which identifies the specific accommodation, ancillary service or billing calculation. 118 Traumatic Brain Injury 119 Private 129 Semi-private 183 Therapeutic Leave Days 185 Hospital Reserve Bed Days 279 Wound Vacuum 412 Ventilator

919 Extreme Behavior
001 Grand Total

- LOCATOR 43** REVENUE DESCRIPTION
A narrative description of the related revenue categories included on this bill.
Abbreviations may be used.
- LOCATOR 44** HCPCS/RATES (MANDATORY)
Enter the accommodation rate for long-term care facilities.
- LOCATOR 45** SERVICE DATE
The date the indicated service was provided.
- LOCATOR 46** UNITS OF SERVICE (MANDATORY)
Enter the number of covered days.
- LOCATOR 47** TOTAL CHARGES (MANDATORY)
Enter total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
Total charges include both covered and non-covered charges.
- LOCATOR 48** NON - COVERED CHARGES
Leave Blank not Required for Long-Term Care Claims.
- LOCATOR 49** UNLABELED FIELD
Leave blank.
- LOCATOR 50** PAYER IDENTIFICATION (MANDATORY)
If the Medical Assistance program is the only payer, enter "Medicaid". If other payers exist, Medicaid is always payer of last resort. Submit a Medical Assistance program claim using CMS 1450 (UB-04) claim form for the total charges and enter in locator 50A and 50B "Payer" as follows:
- | | | |
|----|-----------------------------|-----|
| A) | Medicare | 001 |
| B) | Medicaid | 999 |
| C) | TPL (Third Party Liability) | 141 |
| D) | Patient Copay/ Cost Share | 555 |
- LOCATOR 51** HEALTH PLAN ID
Enter the providers NPI number, 7-digit Medical Assistance Program Provider Identification Number, and/or Proprietary Number for the service being billed.
- 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 (MANDATORY)

Enter the amount the long-term care facility has received toward payment of the bill prior to the billing date by the indicated payer.

LOCATOR 55 ESTIMATED AMOUNT DUE
The amount estimated by the long-term care facility to be due from the indicated payer (estimated responsibility less prior payments).

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

LOCATOR 57 OTHER PROVIDER ID NUMBER
Enter the providers 7-digit Medical Assistance Program Provider Identification Number, which was assigned by the South Dakota Medical Assistance Program and/or Proprietary Number.

LOCATOR 58 INSURED'S NAME (MANDATORY)
Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the South Dakota Medical Assistance Program ID card. If the patient is covered by insurance other than South Dakota Medical Assistance Program, enter the name of the individual in whose name the insurance is carried.

LOCATOR 59 PATIENT'S RELATIONSHIP TO INSURED
A code indicating the relationship of the patient to the identified insured.

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

LOCATOR 61 INSURED GROUP NAME (MANDATORY IF APPLICABLE)
When the Medical Assistance program is secondary payer, enter the insured group name of primary payer.

LOCATOR 62 INSURANCE GROUP NUMBER (MANDATORY IF APPLICABLE)
When the South Dakota Medical Assistance Program is secondary payer, enter the insured group number of the primary payer.

LOCATOR 63 TREATMENT AUTHORIZATION CODE
Required, if services must be prior authorized. Enter prior authorization number here.
If prior authorization is not required leave blank.

LOCATOR 64 DOCUMENT CONTROL NUMBER
Leave Blank. Reserved for Office Use.

LOCATOR 65 EMPLOYER NAME
The name of the employer that might or does provide health care coverage for the insured individual identified in Form Locator 58.

<i>LOCATOR 66</i>	<u>DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION)</u> The qualifier code that denotes the version of International Classification of Diseases (ICD) reported.
<i>LOCATOR 67</i>	<u>PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)</u> Enter the ICD-9-CM code for the principal diagnosis labeled 67. Enter the other diagnosis codes other than the principal diagnosis in form labeled A-Q. The definition of Principal Diagnosis Code is: The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). The definition of Other Diagnosis Codes is: The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, and/or develop subsequently, and which have an affect on the treatment received or the length of stay.
<i>LOCATOR 68</i>	<u>UNLABELED FIELD</u> Leave blank.
<i>LOCATOR 69</i>	<u>ADMITTING DIAGNOSIS (MANDATORY)</u> Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.
<i>LOCATOR 70</i>	<u>PATIENT'S REASON FOR VISIT</u> Leave Blank not Required for Long-Term Care Claims.
<i>LOCATOR 71</i>	<u>PROSPECTIVE PAYMENT SYSTEM (PPS) CODE</u> Leave Blank not Required for Long-Term Care Claims.
<i>LOCATOR 72</i>	<u>EXTERNAL CAUSE OF INJURY CODE (E-CODE)</u> The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.
<i>LOCATOR 73</i>	<u>UNLABELED FIELD</u> Leave blank.
<i>LOCATOR 74</i>	<u>PRINCIPAL AND OTHER PROCEDURE CODES AND DATE</u> Leave Blank not Required for Long-Term Care Claims.
<i>LOCATOR 75</i>	<u>UNLABELED FIELD</u> Leave blank.
<i>LOCATOR 76</i>	<u>ATTENDING PHYSICIAN ID</u> Enter the NPI and name of the individual 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.
<i>LOCATOR 77</i>	<u>OPERATING PHYSICIAN ID</u> Leave Blank not Required for Long-Term Care Claims.

LOCATOR 78-79 **OTHER PHYSICIAN ID (MANDATORY)**
(MANAGED CARE RECIPIENTS ONLY)
 Enter primary qualifier, NPI, and name of the referring, other operating, or rendering physician. Primary qualifiers: DN- Referring Provider, ZZ- Other Operating Physician, or 82- Rendering Physician
 Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 80 **REMARKS**
 Enter former reference number for adjustments and voids.

LOCATOR 81 **CODE-CODE FIELD**
 To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

SPECIAL BILLING INSTRUCTIONS

REPLACEMENT AND VOID CLAIMS

If an error has been discovered when payment has been received and correction is needed, take the following action:

Void Request

A void request asks the Medical Assistance program to take back all the money paid for a claim. Every line is reversed. A paid line has the payment taken back from it. A denied line remains denied. A pending line is denied. The transaction is shown on your remittance advice and the money taken back is deducted from any payment that may be due to you.

To submit a void request, follow the steps below:

- Make a copy of your paid claim.
- Enter the correct Type of Bill in form locator 4.

<u>Claim Type</u>	<u>Replacement</u>	<u>Void</u>
Long Term Care	217	218

- In form locator 80, enter the claim reference number that Medical Assistance assigned to the original claim.
- Highlight form locator 80.
- Send the void request to the address for the department listed on page 23.
- Keep a copy of your request for your files.

If the original claim reference number is not shown on the void request, it will not be processed, and will appear on your remittance advice as an error.

Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

Replacement Request

A replacement request consists of two steps. First, a credit adjustment, or void is generated by the claims payment system, for each line paid on the original claim and processed. This part of the transaction works as described in void processing, above. Secondly, the corrections indicate on the replacement claim are

then processed as new debit claims. All paid lines are processed as you note on each claim line. A denied line remains denied, and a pending line is also denied. The replacement claim may include more or fewer lines than the original. Both transactions are shown on your Remittance Advice; the original paid claim lines are voided and the replacement/adjustment claim lines are paid as new, or debit claims. This may result in either an increased payment or a decreased payment depending upon the changes you noted on the replacement claim.

To submit a replacement request, follow the steps below:

- Make a copy of the paid claim.
- Enter the correct Type of Bill form locator 4

<u>Claim Type</u>	<u>Replacement</u>	<u>Void</u>
Long Term Care	217	218

- In form locator 80, enter the claim reference number that South Dakota Medical Assistance assigned to the original claim.
- Highlight form locator 80.
- Indicate corrections to the claim by striking through incorrect information and entering corrections. Use correction fluid or tape to remove incorrect information and replace with correct information.
- Highlight all the corrections entered.
- Do not attach additional separate pages or use post-it notes. These may become separated from the request and delay processing.
- Send the replacement request to the address for the department listed on page 23.
- Keep a copy of the request on file.

An original claim can be replaced only once. You may, however, submit a void or replacement request for a previously completed replacement. In this case, enter the appropriate Type of Bill code (see above) in form locator 4 and enter the claim reference number of the replacement claim in form locator 80. Highlight form locator 80, enter and highlight any corrections, as described above, and submit your request.

The Medical Assistance claims payment system links the original claim with subsequent replacement and/or void requests, to ensure that any transaction is only replaced or voided once.

BILLING MEDICARE

When an individual is a Medicare and Medical Assistance recipient, Medicare must be billed by the provider as the primary carrier.

LONG-TERM CARE MEDICARE CROSSOVER CLAIMS, USING THE UNIFORM BILLING CLAIM FORM CMS 1450 (UB-04).

Claim forms are not supplied by the Division of Medical Services but must meet the requirements of the South Dakota UB-04 committee.

The claim is a multiple-part form. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for the proper postage.

CODES

The codes specified for use in a Medicaid Management Information System (MMIS) by the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) are:

For Diagnosis:	ICD-9-CM, Internal Classifications of Diseases 9th Edition, Clinical Medicine
For Procedures:	Same as diagnosis
Outpatient Laboratory:	HCPCS or CPT/4
Outpatient Surgical Procedures:	HCPCS or CPT/4

ICD-9-CM code books may be purchased in hard cover or paperback from:

Medicode
5225 Weley Post Way, Ste 500
Salt Lake City, UT 84116-2889

SUBMISSION

The department must receive a provider's completed claim form within 12 months following the month the services were provided, unless third party liability insurance is involved or initial retroactive eligibility is determined.

A provider may only submit a claim for services he knows or should have known are covered by the Medical Assistance program.

The name, which appears on the remittance advice, indicates the provider name, which the DSS associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

HOW TO COMPLETE THE CMS 1450 (UB-04) MEDICARE CROSSOVER CLAIM FORM

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by the Medical Assistance program.

THE FOLLOWING IS A BLOCK BY BLOCK EXPLANATION OF HOW TO PREPARE THE MEDICARE CROSSOVER CLAIM ON THE CMS 1450 (UB04) CLAIM FORM.

- LOCATOR 1** PROVIDER NAME, ADDRESS & TELEPHONE NUMBER
Enter the name of the provider submitting the bill, address, city, state, zip code, and telephone (**MANDATORY**) Fax and Country (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. (See below the only acceptable codes under the South Dakota Medical Assistance Program.)
- Long Term Care
211 Admission through Discharge
212 Interim First Claim
213 Interim Continuing Claim
217 Replacement
218 Void
- LOCATOR 5** FEDERAL TAX NUMBER
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)
Enter in 8a the patient's Medicaid I.D. number from the patient's South Dakota Medical Assistance card. Enter in 8b the patient's full name.
- LOCATOR 9** PATIENT ADDRESS
Enter in 9a the patient's address, 9b city, 9c state, 9d zip code, and 9e country.
- LOCATOR 10** PATIENT BIRTHDATE
Enter patient's birth date.
- LOCATOR 11** PATIENT SEX
Enter patient's sex.
- LOCATOR 12** ADMISSION/START OF CARE DATE
Enter the date the patient was admitted.
- LOCATOR 13** ADMISSION HOUR
Leave Blank not Required for Long-Term Care Claims
- LOCATOR 14** TYPE OF ADMISSION
Leave Blank not Required for Long-Term Care Claims.
- LOCATOR 15** SOURCE OF ADMISSION
Leave Blank not Required for Long-Term Care Claims.
- LOCATOR 16** DISCHARGE HOUR
Leave Blank not Required for Long-Term Care Claims.

LOCATOR 17

PATIENT STATUS (MANDATORY)

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 the South Dakota Medical Assistance Program.)

- 01 Discharges home or self-care (routine discharge) including discharges to foster homes, group homes, halfway houses, and supervised personal care facilities as well as private residences.
- 02 Discharges/transfers/referrals to another short term general hospital such as acute care hospitals, public health service hospitals, neonatal units, etc.
- 03 Discharges/transfers to skilled nursing facilities (SNF) including swing beds, sub acute care centers and Medicare nursing facilities as well as skilled nursing homes.
- 04 Discharges/transfers to intermediate care facilities (ICF) including community support providers, SD Development Center, as well as regular nursing homes.
- 05 Discharges/transfers/referrals to another type of institution such as rehabilitation hospitals or units, military or VA hospitals, Assisted Living Centers, etc.
- 06 Discharges/transfers to home under the care of an organized home health service organization.
- 07 Left against medical advice.
- 20 Expired
- 30 Still an inpatient. This is an invalid code except for DRG-exempt Hospital/Unit claims and Nursing Home.
- 40 Expired in a medical facility

INVALID CODES:

09, 11-19, 21-29, 31-39, 41-99 these are all invalid codes which should not be used for Long-term care claims.

LOCATOR 18-28

CONDITION CODES

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

LOCATOR 29

ACCIDENT STATE

The two letter state abbreviation the accident occurred in. (if applicable)

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 bill 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 bill.
- 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, ancillary service or billing calculation.
 118 Traumatic Brain Injury
 119 Private
 129 Semi-private
 183 Therapeutic Leave Days
 185 Hospital Reserve Bed Days
 279 Wound Vacuum
 412 Ventilator
 919 Extreme Behavior
 001 Grand Total
- LOCATOR 43** REVENUE DESCRIPTION
 A narrative description of the related revenue categories included on this bill. Abbreviations may be used.
- LOCATOR 44** HCPCS/RATES (MANDATORY)
 Enter the accommodation rate for long-term care facilities.
- LOCATOR 45** SERVICE DATE
 The date the indicated service was provided.
- LOCATOR 46** UNITS OF SERVICE (MANDATORY)
 Enter the number of covered days.

- LOCATOR 47** **TOTAL CHARGES (MANDATORY)**
 Enter total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
 Total charges include both covered and non-covered charges.
- LOCATOR 48** **NON - COVERED CHARGES**
 Leave Blank not required for Long-Term Care Claims.
- LOCATOR 49** **UNLABELED FIELD**
 Leave blank.
- LOCATOR 50** **PAYER IDENTIFICATION (MANDATORY)**
 If the Medical Assistance program is the only payer, enter "Medicaid". If other payers exist, Medicaid is always payer of last resort. Submit a Medical Assistance program claim using CMS 1450 (UB-04) claim form for the total charges and enter in locator 50A and 50B "Payer" as follows:
- | | | |
|----|-----------------------------|-----|
| A) | Medicare | 001 |
| B) | Medicaid | 999 |
| C) | TPL (Third Party Liability) | 141 |
| D) | Patient Copay/ Cost Share | 555 |
- LOCATOR 51** **HEALTH PLAN ID**
 Enter the providers NPI number, 7-digit Medical Assistance Program Provider Identification Number, and/or Proprietary Number for the service being billed.
- 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 (MANDATORY)**
 Enter the amount the long-term care facility has received toward payment of the bill prior to the billing date by the indicated payer.
- LOCATOR 55** **ESTIMATED AMOUNT DUE (MANDATORY)**
 The amount estimated by the long-term care facility to be due from the indicated payer (estimated responsibility less prior payments).
- LOCATOR 56** **NATIONAL PROVIDER NUMBER (NPI) (MANDATORY)**
 Enter the provider's National Provider Identification (NPI) number.
- LOCATOR 57** **OTHER PROVIDER ID NUMBER**
 Enter the providers 7-digit Medical Assistance Program Provider Identification Number, which was assigned by the South Dakota Medical Assistance Program and/or Proprietary Number.

- LOCATOR 58** **INSURED'S NAME (MANDATORY)**
 Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the South Dakota Medical Assistance Program ID card. If the patient is covered by insurance other than South Dakota Medical Assistance Program, enter the name of the individual in whose name the insurance is carried.
- LOCATOR 59** **PATIENT'S RELATIONSHIP TO INSURED**
 A code indicating the relationship of the patient to the identified insured.
- LOCATOR 60** **INSURED'S UNIQUE ID NUMBER (MANDATORY)**
 The recipient identification number is the 9-digit number found on the Medical Assistance Program Identification Card. The 3-digit generation number located behind the 9-digit recipient number is not part of the recipients ID number and should not be entered on the claim.
- LOCATOR 61** **INSURED GROUP NAME (MANDATORY IF APPLICABLE)**
 When the Medical Assistance Program is secondary payer, enter the insured group name of primary payer.
- LOCATOR 62** **INSURANCE GROUP NUMBER (MANDATORY IF APPLICABLE)**
 When the South Dakota Medical Assistance Program is secondary payer, enter the insured group number of the primary payer.
- LOCATOR 63** **TREATMENT AUTHORIZATION CODE**
 Required, if services must be prior authorized. Enter prior authorization number here.
 If prior authorization is not required leave blank.
- LOCATOR 64** **DOCUMENT CONTROL NUMBER**
 Leave Blank. Reserved for Office Use.
- LOCATOR 65** **EMPLOYER NAME**
 The name of the employer that might or does provide health care coverage for the insured individual identified in Form Locator 58.
- LOCATOR 66** **DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION)**
 The qualifier code that denotes the version of International Classification of Diseases (ICD) reported.
- LOCATOR 67** **PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)**
 Enter the ICD-9-CM code for the principal diagnosis labeled 67. Enter the other diagnosis codes other than the principal diagnosis in form labeled A-Q.
- The definition of Principal Diagnosis Code is: The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).
- The definition of Other Diagnosis Codes is: The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, and/or

develop subsequently, and which have an affect on the treatment received or the length of stay.

- LOCATOR 68** UNLABELED FIELD
Leave blank.
- LOCATOR 69** ADMITTING DIAGNOSIS (MANDATORY)
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.
- LOCATOR 70** PATIENT'S REASON FOR VISIT
Leave Blank not Required for Long-Term Care Claims.
- LOCATOR 71** PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
Leave Blank not Required for Long-Term Care Claims.
- LOCATOR 72** EXTERNAL CAUSE OF INJURY CODE (E-CODE)
The ICD-9-CM 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
Leave Blank not required for Long-Term Care Claims.
- LOCATOR 75** UNLABELED FIELD
Leave blank.
- LOCATOR 76** ATTENDING PHYSICIAN ID
Enter the NPI and name of the individual 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.
- LOCATOR 77** OPERATING PHYSICIAN ID
Leave Blank not Required for Long-Term Care Claims.
- LOCATOR 78-79** OTHER PHYSICIAN ID (MANDATORY)
(MANAGED CARE RECIPIENTS ONLY)
Enter primary qualifier, NPI, and name of the referring, other operating, or rendering physician.
Primary qualifiers: DN- Referring Provider, ZZ- Other Operating Physician, or 82- Rendering Physician
Enter identifying qualifier and corresponding number when reporting a secondary identifier.
- LOCATOR 80** REMARKS
Enter former reference number for adjustments and voids.

LOCATOR 81

CODE-CODE FIELD

To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

MANDATORY: The provider **MUST** attach the Medicare Explanation of Benefits and any applicable third party Explanation of benefits to EACH claim form.

SPECIAL BILLING INSTRUCTIONS

INPATIENT SERVICES - OUTPATIENT SERVICES - LONG TERM CARE

Separate claim forms are required for each patient/recipient receiving services, i.e. mother and baby (babies).

REPLACEMENT AND VOID CLAIMS

If an error has been discovered when payment has been received and correction is needed, take the following action:

Long-Term Care Claims:

Type of bill 117 or 118 (Locator 4 - type of bill)

Type 117 "Replacement" - prepare a complete CMS 1450 (UB-04) claim form making corrections.

Type 118 "Void" - prepare a complete CMS 1450 (UB-04) claim form, or enter the reference number from the original claim in box 80 for voiding the claim. Previous payment will be deducted from current payments.

Examples of reason(s) an adjustment or void claim should be prepared and submitted:

- 1) Void - wrong recipient number or wrong provider number was used on the claim or entered incorrectly by the Medical Assistance program.
- 2) Adjustment - late charges, 3rd party payment was received or principle diagnosis was incorrect.

MANDATORY:

The provider **MUST** attach the Medicare Explanation of Benefits and any applicable third party explanation of benefits to EACH claim form.