UB-04 MEDICARE CROSSOVER CLAIM INSTRUCTIONS

UB-04 MEDICARE CROSSOVER CLAIMS

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 if you have received your Medicare EOB more than 30 days ago and a remittance advice from Medicaid does not show the claim has been pended, denied, or paid.

Please refer to the UB-04 Third-Party Liability Claim Instructions to complete a UB-04 claim when the primary payer is private or other type of insurance company.

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

LOCATOR 1 — **PROVIDER NAME, ADDRESS & TELEPHONE NUMBER (MANDATORY)**
Enter the provider DBA Name as shown in the Organization Business Name on the SD Medicaid Provider Enrollment Portal enrollment record, address, city, state, zip code and telephone.

Fax and country are optional.

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

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

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

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

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

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

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

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

LOCATOR 7 UNLABELED FIELD
Leave Blank

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

LOCATOR 9 PATIENT ADDRESS
Optional

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

LOCATOR 11 PATIENT SEX
Optional

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

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

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

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

Admission Type 2 - Indicates the Medicaid recipient was treated for urgent care. If marked urgent for a recipient in the Primary Care Provider (PCP)/Health Home (HH) Programs and the NPI of the PCP/HH is not in Block 78 or 79, Medicaid will

reimburse the emergency room (450 revenue code) only. Any treatment (ancillary charge) is then the responsibility of the Medicaid recipient.

Admission Type 3 - Indicates the Medicaid recipient was treated for elective care. If there was an actual referral from the PCP/HH then Block 78 or Block 79 must contain the recipient's PCP/HH NPI number.

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

This field is mandatory for all inpatient claims. All other claim types may leave this field blank.

Point of Origin for Admission or Visit

0 Indian Health Services or 638 contract care providers

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, 7-9

LOCATOR 16 **DISCHARGE HOUR (CONDITIONALLY MANDATORY)**

This field is mandatory for all inpatient claims. All other claim types may leave this field blank.

Enter the hour the patient was discharged from inpatient care.

LOCATOR 17 **PATIENT STATUS (MANDATORY)**

Please enter the appropriate discharge status.

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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; 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 - used only when the patient dies

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

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

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

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

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

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

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

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

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

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

63 Discharged/transferred to a long-term care hospital

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

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

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

69 Discharged/transferred to a designated disaster alternative care site

70 Discharged/transferred to another type of health care institution not defined elsewhere in the code list

81 Discharged to home or self-care with a planned acute care hospital inpatient readmission

82 Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission

83 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission

84 Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission

85 Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission

86 Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission

87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission

88 Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission

89 Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission

90 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission

91 Discharged/transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission

92 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission

93 Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission

94 Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission

95 Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

INVALID CODES:
08, 10-19, 22-29, 31-39, 44-49, 52-60, 67-68

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.

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

LOCATOR 37 — UNLABELED FIELD
Leave Blank

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

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

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

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

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

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

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

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

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

Please view additional guidance for NDC billing here.

LOCATOR 44 **HCPCS/RATES (CONDITIONALLY MANDATORY)**

HCPCS are required on applicable outpatient claims when there is a known HCPC association with the service provided.

Enter the usual and customary rate for inpatient claims. Enter the usual and customary rate and the HCPCS applicable on outpatient claims.

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

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

Non-OPPC modifier that must be billed primary modifier on the claim:

- Claim procedure code modifier: **GT** must be used with telemedicine revenue code 780 for inpatient claims

LOCATOR 45 **SERVICE DATE (CONDITIONALLY MANDATORY)**

The date the indicated service was provided.

The date the indicated service was provided.

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

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

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

LOCATOR 47 **TOTAL CHARGES (MANDATORY)**

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

LOCATOR 48 NON - COVERED CHARGES

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
141 Primary Health Insurance
999 Medicaid
555 Recipient's Medicaid Hospice or Nursing Home Cost Share

If Medicare denies the claim (all lines), then the claims need to be submitted as Medicaid primary (999 in locator 50A) with the Medicare EOMB attached. When Medicare is paying partial claims lines, the claim will need to be split.

South Dakota Medicaid will pay the copay, coinsurance, and deductible on the lines where Medicare paid, as one claim (001 in locator 50A). A separate claim will need to be submitted for those lines where Medicare is denied but needs to come in as a Medicaid Primary for coverage (999 in locator 50A).

LOCATOR 51 HEALTH PLAN ID

Enter the corresponding plan ID number from 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 (MANDATORY)**

54a. Enter the payment amount from the payer in 50 a.
54b. Enter the payment amount from the payer in 50 b. If payer is South Dakota Medicaid leave blank.
54c. Enter the payment amount from the payer in 50 c. If payer is South Dakota Medicaid leave blank.

All pages of the claim must have the same amount listed in locator 54.

LOCATOR 55 **ESTIMATED AMOUNT DUE (MANDATORY)**

Leave locator 55A and 55B blank and in 55C enter the total estimated copay, coinsurance, and/or deductible amount 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
Prior authorization is not required, leave blank.

LOCATOR 64 — DOCUMENT CONTROL NUMBER
Leave blank

LOCATOR 65 — EMPLOYER NAME
Optional

LOCATOR 66 — **DIAGNOSIS AND PROCEDURE CODE QUALIFIER (MANDATORY)**
The qualifier code that denotes the version of International Classification of Diseases (ICD-10) 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. Included in DRG assignment. No payment effect for non-DRG hospitals.
N	Diagnosis was not present at time of inpatient admission. Health Care-Acquired Conditions (HACs) coded with POA of "N" are excluded from DRG assignment. For non-DRG hospitals to the extent that the cost of the condition can be isolated payment for the cost of the condition will be denied.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. Heath Care-Acquired Conditions (HACs) coded with POA of "N" are excluded from DRG assignment. For non-DRG hospitals to the extent that the cost of the condition can be isolated payment for the cost of the condition will be denied.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. Included in DRG assignment. No payment effect for non-DRG hospitals.
1	Exempt from POA reporting. This code is equivalent of leaving the field blank.

LOCATOR 68 — UNLABELED FIELD
Leave blank.

LOCATOR 69 — **ADMITTING DIAGNOSIS (CONDITIONALLY MANDATORY)**
For Inpatient Claims Only:
Enter the diagnosis code provided at the time of admission as stated by the physician.

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.

When submitting a crossover claim for dual eligible Medicaid/Medicare recipients in the Health Home program, if the provider is a type two provider, the claim must still be submitted with the ordering/referring type one provider information on the claim to avoid a denial and to remain in alignment with Medicare guidance.

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											

QUICK ANSWERS

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

   Confirm your taxonomy in the SD provider enrollment portal and compare it to the populated taxonomy in 81 CC A.

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

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

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

   Yes.

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

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

5. **I submitted to Medicare a bill type that is not a South Dakota Medicaid accepted bill type. What do I need to do?**

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

6. **Can I bill an electronic crossover claim directly to South Dakota Medicaid?**

   No, South Dakota Medicaid only accepts electronic crossover claims from the Medicare Administrative Contractor (MAC).

7. **How do I submit a claim when Medicare denies part or all of the claim lines?**

   If Medicare denies the claim (all lines), then the claim needs to come as a Medicaid Primary (999 in locator 50A) with the EOMB attached. When Medicare is paying partial claims lines, the claim will need to be split.
   South Dakota Medicaid will pay the copay, coinsurance, and deductible on the lines where Medicare paid, as one claim (001 in locator 50A). A separate claim will need to be submitted for those lines where Medicare is denied but needs to come in as a Medicaid Primary for coverage (999 in locator 50A).

   An example would be PR 97 if Medicaid covers the services; dental procedures.